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# Montana Strategic Plan to Provide More Affordable Health Care Coverage

**Summary of the Montana State Planning Grant Recommendations**
**August 2004**

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Funded through a HRSA State Planning Grant
Presented to the Honorable Governor Judy Martz, the Montana Legislature, the Citizens of the State of Montana and the Secretary of the U.S. Department of Health and Human Services

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DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

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August 2004

To: Interested Parties

From: Gail Gray, Director and Co-Chair, State Planning Grant
Tanya Ask, Co-Chair, State Planning Grant

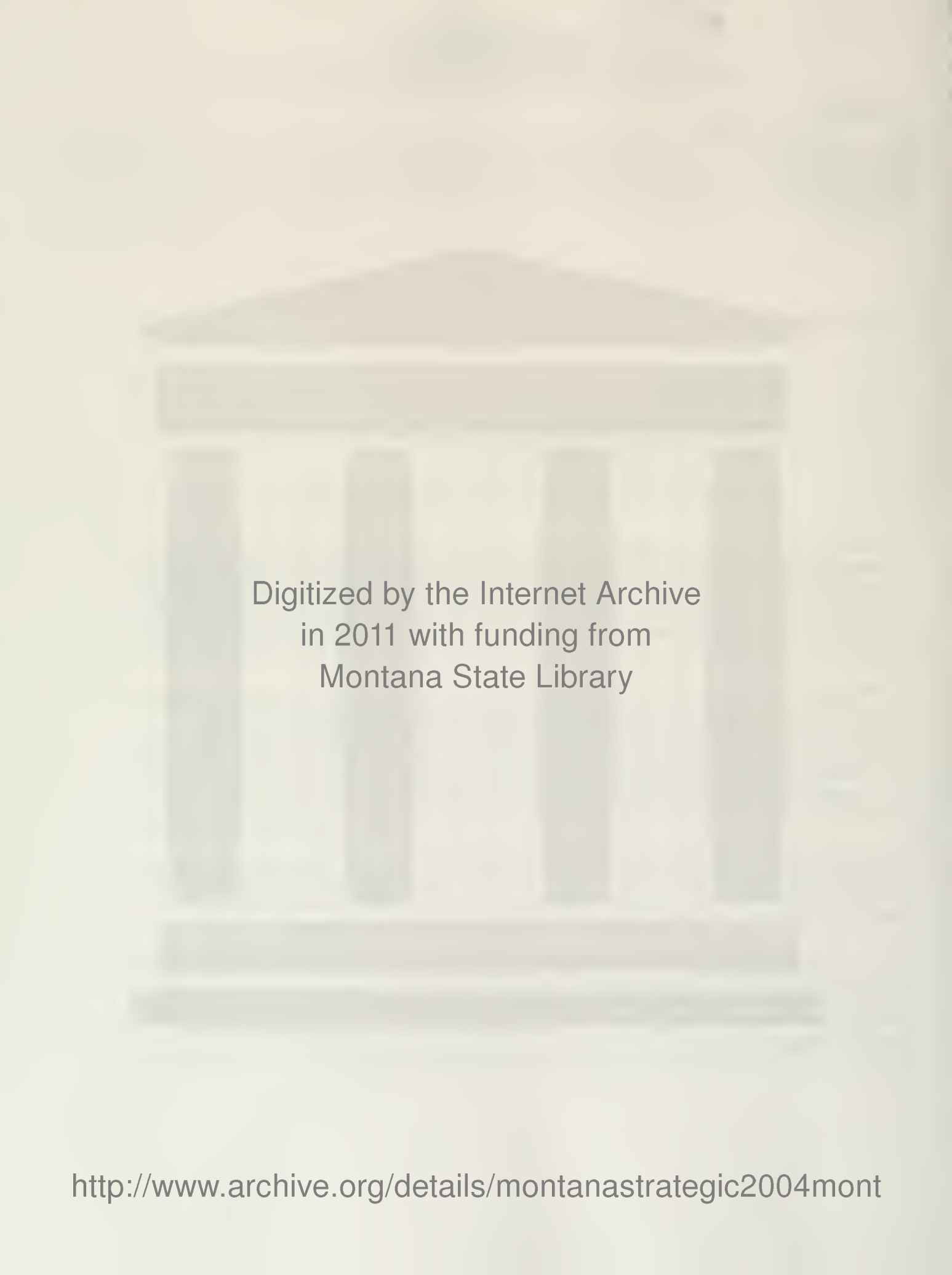
Re: Montana Strategic Plan to Provide Affordable Health Care Coverage

Enclosed, please find a copy of *Montana's Strategic Plan to Provide Affordable Health Care Coverage, A Summary of Montana's State Planning Grant Recommendations.* In July of 2002, the Montana Department of Public Health and Human Services was awarded a planning grant from the Health Resources and Services Administration in order to conduct an analysis of Montana's uninsured population and obtain Montana specific data about the uninsured. The receipt of this grant provided an opportunity to continue the discussions of the 2002 and 2003 Governor's Health Care Summit.

For the past two years, a state-wide cross section of public and private leaders appointed by Governor Martz to the SPG Steering Committee, appointed by Governor Martz, has guided the project development, implementation and identification of recommendations. We would like to express our thanks to the staff and members of the Steering Committee and the three work groups: Data, Safety Net and Coverage Options, for their tireless efforts in reviewing resources, analyzing data and identifying feasible solutions. The individuals that comprised the State Planning Grant Committees represented health care insurers and providers, low-income advocacy, Indian Health Services, senior citizens, legislators, businesses and chambers of commerce.

The partnership and technical support of the Bureau of Business and Economic Research (BBER) from the University of Montana and the State Health Access Data Assistance Center (SHADAC), University of Minnesota resulted in the largest and most comprehensive surveys on health insurance that have been conducted in Montana. Their expertise and guidance has been invaluable to this project.

The State Planning Grant (SPG) Steering Committee identified an incremental approach of coverage options to provide affordable health insurance coverage between 2004 and 2010. The vision of the State Planning Grant, in cooperation and coordination with the public and private sector is to provide affordable health care coverage for all Montanans', strengthen the health care safety net across Montana and reduce, by 2010, Montana's uninsured rate by 50%, with an emphasis on covering children. As you will see from this report, there is no one solution that will erase the problem of the uninsured in Montana.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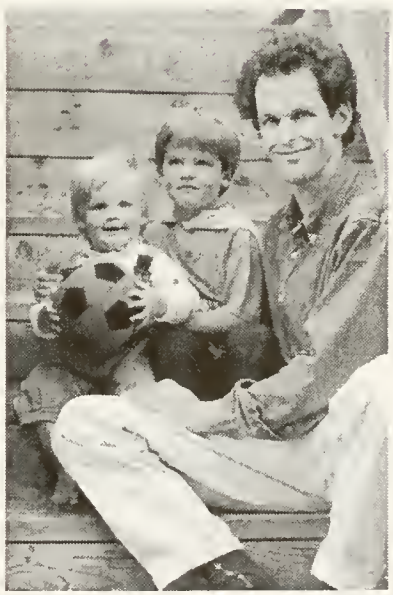

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# Executive Summary

Prior to the receipt of the State Planning Grant (SPG), Montana has had to rely on data through federal or private efforts to describe its uninsured population. In July of 2002, the Montana Department of Public Health and Human Services was awarded a planning grant from the Health Resources and Services Administration (HRSA) in order to conduct an in-depth analysis of Montana's uninsured population, obtain Montana specific data about the uninsured and develop a six-year strategic plan to provide the uninsured access to affordable health insurance coverage.

This report presents the results of the project. Governor Martz appointed a twenty member SPG Steering Committee to guide the project development and implementation. Representatives included individuals from across the state representing a cross section of key public and private stakeholders from across the state, including business and industry, minority populations, nonprofit groups, health care delivery professionals, the health insurance sector, state agencies and consumers. In addition, three work teams assisted the Department of Public Health and Human Services, the Grant Director, and the researchers in various aspects of the grant projects. Work teams supporting the project included the Data Team, the Safety Net Team, and the Coverage Options Team.

The Montana Department of Public Health and Human Services contracted with the University of Montana's Bureau of Business and Economic Research to conduct two surveys: the Montana Household and the Montana Employer Survey. These surveys were developed in consultation with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota and with the assistance of the Data Team. The University of Montana also completed six focus groups and 30 key informant interviews.

Montana has historically had one of the higher rates of uninsurance in the nation. Depending on the source of data, current estimates of uninsurance in Montana range from 14 percent of the population to 19 percent. This report presents findings from the 2003 Montana Health Insurance Survey, the largest and most comprehensive survey on health insurance that has been conducted in Montana to date. Consistent with earlier studies, the survey finds a relatively high overall rate of uninsurance in Montana, with 19 percent of the population uninsured at the time of the survey.

Because of the way the 2003 household survey was designed, the state is able for the first time to make detailed estimates of uninsurance rates for various population groups within the state, such as rates by age or race and ethnicity. Although the overall rate of uninsurance in Montana is high, the survey finds substantial variation in uninsurance rates within various population groups including:

- Young adults, particularly between the ages of 19 and 25, were more than twice as likely to be uninsured than the general population.
- Montana's American Indian populations experience uninsurance at much higher rates that were two times higher compared to the statewide average.
- Insurance status also varies by income level with Montanans who have incomes below the federal poverty level being about 2 times more likely to be uninsured than the statewide average.

The 2003 Montana Household Survey on Health Insurance asked specific questions about other issues of interest to policy makers, such as medical debt, insurance affordability, and individual insurance policies and found that:

- Uninsured persons were more than 3 times as likely to have medical debt (21%) compared to those with health insurance (7%);
- Average medical debt was $2500 or higher and represented as much as 16 percent of household income for persons without health insurance;
- Being uninsured is not voluntary with 90 percent of the uninsured reporting being unable to buy health insurance after paying for food, clothing, and shelter;
- Uninsured can afford to pay low monthly premiums, averaging about $96 per month;

## Executive Summary *(continued)*

- Montana's uninsured did have coverage in the past with only 20 percent reporting no previous health insurance;
- High average deductibles of more than $3000 for persons with individual insurance policies;
- Individual insurance policies take a big bite of monthly household income ranging from 21 percent for people below twice the poverty level and 8 percent for persons more than 2 times (200%) above the poverty level.

A key objective of the employer survey was to fill in gaps in our knowledge about Montana business offering of health insurance to their employees. Major findings for Montana employers include:

- Over 40 percent of small firms with 10 or fewer employees offer health insurance;
- One third of small firms offering health insurance offer it to all employees;
- More than 90 percent of large firms with 100 employees offer health insurance;
- Only half of large firms offering health insurance offer it to all employees;
- For the 81 percent of Montana firms not offering health insurance, high premiums are cited as the major reason why they do not offer insurance;
- More than 80 percent of employers cite higher prices for hospital care, prescription drugs, physician care, and malpractice insurance as major reasons for health insurance premium increases;
- Less than 30 percent of firms not offering insurance thought they would provide insurance under a tax credit policy;
- More than 40 percent of firms not offering insurance indicated they would 'absolutely' participate in a small business purchasing pool.

# Montana State Planning Grant

## 2010 Vision for Uninsured Montanans

### Background

Developing a strategic plan to provide the uninsured access to affordable health insurance coverage is one of the goals derived from the State Planning Grant. Prior to the receipt of the State Planning Grant Montana relied on data from federal or private resources to describe its uninsured population. In July of 2002, the Montana Department of Public Health and Human Services was awarded a planning grant from the Health Resources and Services Administration (HRSA) in order to conduct an in-depth analysis of Montana's uninsured population, and obtain Montana specific data about the uninsured and review services provided by Montana's Safety Net providers.

Over the past two years, a twenty member SPG Steering Committee, appointed by Governor Martz has guided the project development, implementation and recommendations. Representatives included individuals from across the state representing a cross section of key public and private stakeholders, including consumers, business and industry, minority populations, nonprofit groups, health care delivery professionals and facilities, the health insurance sector, and state agencies. In addition, three work teams supporting the project include the Data Team, the Safety Net Team and the Coverage Options Team.

The Montana Department of Public Health and Human Services contracted with the University of Montana's Bureau of Business and Economic Research to conduct two surveys: the Montana Household and the Montana Employer Survey. Additional anecdotal information was collected through six focus groups and thirty key informant interviews.

### Findings

Overall, 19% of Montanans, or approximately 173,000 people were uninsured at the time of the 2003 Montana Household Survey. Health insurance rates among Montana residents vary considerably by age. The survey found that children of Montana, 18 years of age and younger, have an uninsured rate of 17%. For young adults between the ages of 19 and 25, the uninsured rate is 39%. The age group of 26 to 49 year olds has a 24% uninsured rate, while older Montanans between the age of 50-64 have an uninsured rate of 14%.

**Montana's Uninsured - by age, percentage rate and numbers**

| | | |
|---|---|---|
| All ages: | 19% uninsured = | 173,000 Montanans |
| Age 0-18 | 17% uninsured = | 41,500 children |
| Age 19-25 | 39% uninsured = | 32,000 young adults |
| Age 26-49 | 24% uninsured = | 75,000 adults |
| Age 50-65 | 13% uninsured = | 24,000 adults |
| Age 65+ | 0.5% uninsured = | 1,000 adults |

Additional statistical analysis provided by the University of Montana Bureau of Business and Economic Research indicates that of the 41, 500 uninsured children, approximately 22,000 are below 150% of the Federal Poverty Level (FPL). Steve Seninger, Ph.D., Health Economist from the University of Montana, using Household Survey data and data from the MT. Department of Labor, estimated 48% of Montana children eighteen years of age and lower live in households with incomes at less than 200% FPL (considering the per capita income and wages).

# 2010 Vision for Montana

The Committees of the State Planning Grant provided invaluable input into the design of the study, a review of existing public and private programs, a study of Montana legislative efforts to reduce the number of uninsured, an examination of efforts by other states, and an analysis of the safety net of health care providers in Montana as well as gleaning information and advice from committee members, consumer groups and other interested parties. In addition the committee reviewed the state's efforts to reduce our uninsured. A summary of those efforts from 1991-2003 is summarized in Appendix A.

There is no one solution that will address the problem of the uninsured in Montana. A number of approaches and strategies have been recommended to reduce the number of uninsured, while at the same time promote the value of health literacy and the use of evidenced based practices, and assure more affordable health care options. The strategic plan focuses on expanding existing programs, maintaining public-private partnerships, and enacting legislation to maintain as well as create new programs that will help reduce our uninsured numbers.

In order to achieve our overall vision, the State Planning Grant process has identified an incremental approach over the next six years to reduce the number of uninsured and promote more healthy Montanans.

The recommendations, grouped in four categories are summarized on pages 5-7. Detailed information about each recommendation is provided on pages 8-25. Appendix B identifies a variety of information, including the type of coverage, the proposed numbers to be identified by the strategy, and the proposed year of implementation between 2004 and 2010. The strategies combine a variety of approaches in the public and private healthcare market, utilize state and federal dollars, involve individual and employer insurance market, as well as the public sector. The Coverage Options strategies are summarized in the graphic found in Appendix C. The value of providing more accessible healthcare and ultimately reducing Montana's uninsured rate will offer significant returns to Montana's overall economy and its number one resource – our citizens.

For those recommendations that require revenue, we recommend the use of the revenue generated by the interest from the Tobacco settlement and the dollars identified by the proposed tobacco tax.

The vision of the State Planning Grant efforts between 2004 and 2010, with the cooperation and coordination of the public and private sector is to:

- Provide affordable health care coverage for all Montanans
- Strengthen the health care safety net across Montana
- Reduce, by 2010, Montana's uninsured rate by 50%, with an emphasis on covering children.

# Summary of Coverage Options Recommendations

## I. No Significant Fiscal Impact to the State of Montana:

A. Encourage Associations and groups to explore the benefits of purchasing pools, given the legislative changes made in the 2003 legislative session.

B. University System:

1. Recommend the Commissioner of Higher Education, Board of Regents and the University/Community College system develop consistent internal policies and procedures to require proof of existing insurance coverage (parents or employers) or require students to purchase health insurance offered through the University System.

C. Health Literacy:

Educate the public in the benefits of health insurance coverage by promoting health literacy and the value of maintaining one's health.

1. Improve health promotion with consumers and employers (i.e. wise pharmacy)
2. Promote preventive health curricula within the education system. (Consumer Education, General Life Skills, Driver's education, etc.)

## II. Requires new state legislation and/or new state dollars

A. Safety Net:
Recognize and support the Safety Net (Community Health Centers, FQHC, Urban Indian Clinics etc.) as a vital component of the health care delivery system. Support recommendations to enhance the Safety Net's ability to operate throughout the state. Recommendation includes a request for State funding.

B. Private Market:
Sustain and expand health insurance options in the private market.

1. Continue to pursue tax credits options for low-income individuals with family incomes less than 175% FPL and employers with fewer than 5 employees who do not have any employees earning more than $150,000 per year. Continue to pursue tax credit incentives at 50% employer level and for individuals at 175% Federal Poverty Level (as introduced in 2003 Legislative Session: HB 204 and HB 216) Explore capping available tax credits at maximum of $10 M per year.

2. Explore the feasibility of reducing cost drivers such as mandated benefits, utilization and administrative complexities. Creative approaches should include consideration of basic benefit designs, care manage ment programs, benefit limits and caps, cost sharing by consumers, and streamline of applications and paperwork related to healthcare coverage.

3. Pursue development of legislative proposals that encourage employer sponsored health care plans like the currently available individual only plans such as Blue Care or the New West Bridge Plan.

## III. Requires Legislation and/or a State Funding mechanism

A. Enroll children currently eligible for Medicaid and CHIP
1. Medicaid
2. CHIP (at or below 150% Federal Poverty Level (FPL)

B. Expand CHIP:

Provide CHIP coverage for uninsured children up to 200% FPL (Federal Poverty Level.)

1. Expand CHIP to cover children at 200% Federal Poverty Level
   a) Expand CHIP in graduated increments (165% FPL, 185%, 200 %)
2. Institute increased cost sharing for children between 151-% - 200% Federal Poverty Level.

C. MCHA:

Maintain or increase the Montana Comprehensive Health Association (MCHA) high-risk pool availability of coverage through:

1. Ensuring enrollment for those currently eligible.
2. Maintaining or increase the low-income premium assistance state subsidy established by the 2003 Legislature.
3. Exploring the possibility of expanding the current premium assistance program for eligible individuals from 150% Federal Poverty Level to 200% Federal Poverty Level.
4. Continuing participation in the Trade Adjustment Assistance (TAA) and consider support for Trade Adjustment Assistance expansion.
   a. If an individual is TAA qualified, one can receive tax credits and participate in the portability pool.
   b. Additional TAA support is available through a federal grant for the entire MCHA, not just those who are eligible for TAA credit. MCHA, a current TAA grant recipient should apply for future grants as they become available.

D. Prescription Benefit:

Explore a prescription benefit for those adults:

1. Between the ages of 62-64, up to and including 200% FPL and
2. Who have applied for disability and have the two-year waiting period.

## IV. Public Health Redesign Committee Recommendations

A. General Recommendations:

1. Address those currently eligible under existing programs that are not enrolled in Medicaid or CHIP.
   a. Document and track barriers for those who do not apply for programs for which they are eligible.
   b. Continue collaboration with existing groups to enroll Native Americans in Medicaid and/or CHIP if eligible.
   c. Resume outreach to potentially eligible Medicaid and CHIP children

2. Expand CHIP to cover children at 200% FPL.
   a. Expand CHIP in graduated increments (165% FPL, 185% FPL)
   b. Expand CHIP to cover children at 200% Federal Poverty Level.
   c. Institute increased cost sharing for children between 151-% - 200% Federal Poverty Level.

3. Administrative Issues:
   Maintain health care access for low-income Montanans by addressing Medicaid reimbursement and streamlining, and where possible administrative requirements.

B. Waiver Considerations:

[Addressing the groups identified below would target a large number of uninsured parents in the 19-50 year old age category; parents who work for small businesses and/or parents who are unable to purchase coverage through their employer.]

1. Insure parents/guardians of publicly insured children with the following considerations:

a. At minimum, insure parents/guardians at or below 100% FPL.

b. Consider premium assistance program or a basic medical plan, which may have limits, exclusions and/or capped coverage for certain services.

c. Explore a modified self-directed concept (similar to the Home & Community Based Waiver), which provides the consumer with capped basic benefits, where the consumer shares an increasing responsibility for his/her own health care. Consider a plan, using a debit card that is up front loaded, with consumer knowledge of balance.

2. Expand Medicaid to cover parents/guardians between 101-150% FPL.

   a. Provide a premium assistance program or a basic medical plan, which may have limits, exclusions and/or capped coverage for certain services.

   b. Explore a modified self-directed concept (similar to the Home & Community Based Waiver), which provides the consumer with capped basic benefits, where the consumer shares an increasing responsibility for his/her own health care. Consider a plan, using a debit card that is up front loaded, with consumer knowledge of balance.

3. Explore options to provide coverage to Mental Health Service Plan recipients and/or low income working adults:

   a. Provide a premium assistance program or a basic medical plan, which may have limits, exclusions and/or capped coverage for certain services.

   b. Explore a modified self-directed concept (similar to the Home & Community Based Waiver), which provides the consumer with capped basic benefits, where the consumer shares an increasing responsibility for his/her own health care. Consider a plan, using a debit card that is up front loaded, with consumer knowledge of balance.

## Section I - No Significant Fiscal Impact to the State of Montana

### I. A. Recommendation:

Encourage Associations and groups to explore the benefit of purchasing pools, given the legislative changes made in the 2003 Legislative session.

**Target Population:**

Groups of 51 or more eligible individuals

**Support/Rationale:**

Private sector recommendation

The 2003 Legislative Session, in House Bill 104, lowered the number of eligible individuals needed to form a purchasing pool from 1000 to 51. This recommendation offers new coverage or makes continuing coverage affordable.

The 2003 Montana Household and Employer Survey identified that 77% of Montana's uninsured are employed. The survey found that sixty percent of the State's uninsured are either self-employed or work for a small business with ten or fewer employees.

Recently two Associations announced the availability of an insurance plan. The Montana Nonprofit Association (MNA), after over a year of study and analysis, partnered with New West Health Services, to offer lower cost health care insurance through an Association plan. This plan includes coverage for single employee nonprofit groups. Montana Chamber Choices (MCC) is available to small employers with 2 to 50 employees who are members of a local chamber or the State Chamber. MCC, in association with Blue Cross Blue Shield of Montana offers three standard health insurance options.

**Administrative Issues:**

Staff resources from within Association(s) associated with research of potential plans, projections of take-up rates; benefit design and other related start-up.

**Cost:**

No state funding involved

**Funding Sources:**

Employer and employee

**Implementation:**

*Encourage current associations to poll their members to identify the number of uninsured and facilitate opportunities to train members about available options.

* Encourage the Chamber of Commerce and MNA to track the take-up rate with their respective association plans.

*Outreach and employer education to other Associations by the State Auditor, Chamber of Commerce, National Federation of Independent Business (NFIB), the Montana Society of Association Executives.

## I. B. Recommendation:

1. Recommend the Commissioner of Higher Education, Board of Regents and the University/Community College system develop consistent internal policies and procedures to require proof of existing insurance coverage (parents or employers) or require student to purchase health insurance offered through the University System.

**Target Population:**

Uninsured, at minimum between the ages of 18-26. The requirements may provide an avenue for insurance coverage for those full-time students over the age of 26. 18% of undergraduates at the University of Montana are age 25 or older.

The University of Montana and Montana State University had a total enrollment of approximately 25,000 students, with over 19,000 students considered full-time. Almost 82% of the students attend school on a full time basis.

**Assumption:**

One half of the full-time students are covered by their parents' policies (9500); one-quarter purchase insurance or is covered through University Plan, employer or spouse (4750). This recommendation could potentially reduce the uninsured by more than 4750 individuals.

**Target Number of Uninsured this proposal will address:**

Potentially more than 4,750 post-secondary students.

**Support/Rationale:**

**Public and public-private sector recommendation)**

The Montana Household survey findings identified a 39% uninsured (32,000 individuals) for people between the ages of 19-25. The uninsured rate for those between the ages of 26-49 is 24% (75,000 adults) Montana State University (Bozeman and Billings campus) and the University of Montana (Missoula) campus have existing internal policies and procedures to require proof of insurance for students carrying twelve or more credits.

The premium cost for students to purchase the University policy is approximately $400 per semester.

**Administrative Issues:**

Consistency in implementation and enforcement

**Cost:**
No state cost.

**Recommendation:**

*Commissioner of Higher Education and the Board of Regents implementation of a statewide policy.

## I. C. Recommendation:

Educate the public in the benefits of health insurance coverage by promoting health literacy and the value of maintaining one's health.

1. Improve health promotion with consumers and employers (i.e. wise pharmacy)
2. Promote preventive health curricula with the education system (Consumer Education, General life skills, Driver's education etc.)

**Target Population:**

All Montanans

**Support/Rationale:**

Public /private recommendation

The Montana Household Survey and the Employer Survey identified increased health care costs and health insurance affordability as critical issues for Montanans. Health literacy is defined by Healthy People 2010 as "the degree to which people can obtain, process and understand basic health information and services they need in order to make health decisions." Health literacy is about the entire process of exchanging healthcare information. The National Academy on an Aging Society reports that "over 90 million adults with low health literacy skills have limited ability to read and understand the instructions contained on prescriptions or medicine bottles, appointment slips, informed consent documents, insurance forms, and health education materials...the estimated additional health care expenditures due to low health literacy skills are about $73 billion in 1998 health care dollars." When we better understand health information and the benefits of healthier life styles, we help tackle the cost issues.

Promoting health literacy provides formal and informal avenues of targeting all ages of the uninsured across Montana. Surgeon General Richard Carmona, at the 2003 Governor's Health Care Summit in Billings stated, "Health Literacy can save lives, save money and improve the health care and well-being of millions of Americans."

**Administrative Issues:**

Coordination of efforts, especially given the rural nature of our state is critical. Encourage collaborative partnerships in sharing of information and the message.

**Cost:**

Unknown

**Funding Sources:**

Explore grant applications, such as Robert Wood Johnson Foundation, federal grants, etc.

Implementation:

Includes, but is not limited to:

*DPHHS, as the primary coordinator, in collaboration with state agencies (Commerce, Labor, Insurance Commissioner, OPI, University System,) and the private sector, to promote health wellness.
*Explore existing technology avenues in Montana to enhance opportunities to deliver the message of health literacy (telecommunications, web sites, Public Service Announcements etc.)
*Promote role of Advisory Council on Work Life Wellness.
*Office of Public Instruction to encourage the development of curriculums in primary and secondary education settings (health classes, life skill classes)
*Montana Hospital Association, Community Health Fairs and Health Screenings
*Continued collaboration with the 32 Public Health Advisory Councils
*Media literacy with Montana Broadcasters, Montana Newspaper Association, School of Journalism
*Partner with organizations that interact with the uninsured, working poor and under-insured.
*Explore the 211 concept (telephone access, statewide and/or regionally to health care information)
*Collaboration with Montana Safety Net providers
*AARP/Montana Senior Citizen Association outreach
*Head Start and early childhood program outreach to families and young children

## Section 2 - Requires New State Legislation and/or New State Dollars

### II. A. Recommendation:

Recognize and support the Safety Net (Community Health Centers, FQHC, Urban Indian Clinics etc.) as a vital component of the health care delivery system. Support recommendations to enhance the Safety Net's ability to operate throughout the state.

**Target Population:**

Uninsured, under-insured and low-income residents. Currently fourteen rural communities are interested in pursuing grants to be designated as a Community Health Center. (Kalispell, Plains, Miles City, Lewistown, Baker, Ekalaka, Fort Benton, White Sulphur Springs, Cut Bank, Shelby, Hamilton, Townsend, Sheridan and Conrad).

**Support/Rationale:**

Public/private sector recommendation

Within the development of the five year strategic plan, it is not feasible to achieve a 100% uninsured rate in Montana, therefore the on-going development of primary and preventive health care access is critical. The uninsured, under-insured and low-income of Montana are served by a significant number of safety net health care providers across the State. Safety Net services are part of the fabric of providing health care to all Montanans, especially given our frontier designation.

The U.S. Public Health Act provides federal funds to three major programs in Montana:

- Community Health Centers
- Migrant Health Centers
- Homeless Programs.

Montana is currently served by eleven Community Health Centers in fifteen different communities across Montana. The Montana Migrant Program, headquartered out of Billings, also provides seasonal services in nine sites across the state. The Homeless program, based out of Billings provides satellite services in three communities. In addition, since 1998, through the Rural Hospital Flexibility Program, 35 Montana communities have received designation as Critical Access Hospitals. With the cost-based reimbursement (Medicaid and Medicare), many rural communities were able to maintain health care access for under-insured, uninsured and low-income Montanans.

Based on 2002 data, approximately 75% of the people who used Community Health Center services, had incomes below 100% of the federal poverty level. In addition, approximately 15 of those served were privately insured; just over 20% had Medicaid and/or Medicare coverage. The Community Health Centers provide primary and preventive care to the uninsured across the state. Supporting the development of additional Community Health Centers will provide additional health care access as well as bolster economic development opportunities for our smaller communities. The Montana Primary Care Association has identified more than $8 million dollars in direct federal grant dollars coming to local Montana communities as a result of the existing grants. Ongoing services are supported by a variety of funding sources including, but not limited to: patient fees, donations, Medicaid and Medicare payments, contracts, private insurance etc. A minimum of $300,000 yearly is provided to these communities through these grant funds.

Health care services to Native Americans are provided through Indian Health Services, Urban Indian Clinics, tribal facilities and other safety net providers. Funding for health care services to those Native Americans who are Medicaid eligible and receive services directly from Indian Health Services or tribal facilities are paid with 100% federal funds. As identified in the 2004 Public Health Redesign report, "... 100% federal reimbursement is only available for those services allowable under the state's approved Medicaid State Plan."

**Administrative Issues:**

Technical support is necessary to support the small, rural communities in completing the federal grant applications.

**Cost:**

Provide state funding options to assist small rural communities in their grant applications for various federal programs which will help improve health care access and promote local economic development such as:

1. $50,000 yearly appropriation to provide five communities with start-up funds to initiate and complete the grant process or
2. Provide an appropriation to create a 50-50-state/community match to help communities with resources to help with the grant processes.

**Funding Sources:**

Tobacco Initiative dollars, Community Block Grant dollars, and/or state funding.

**Recommendations:**

*Primary Care Bureau of DPHHS identification of the health care professional shortage areas and related program placement of health care professionals in programs like the National Health Service Corp.

*Montana Primary Care Association to provide technical assistance to the rural communities in their CHC grant applications.

*Montana Hospital Association (MHA) – An Association of Montana health care providers to continue to provide technical assistance to rural communities and their designation as Critical Access Hospitals.

## II. B. Private Market Recommendation:

Increase the affordability of health care insurance and expand health insurance options in the private market by providing tax incentives to low-income individuals and small employers.

1. Pursue tax credits options for low-income individuals with family incomes less than 175% FPL and employers with fewer than 5 employees who do not have any employees earning more than $150,000 per year. Continue to pursue tax credit incentives at 50% employer level and for individuals at 175% Federal Poverty Level (as introduced in 2003 Legislative Session: HB 204 and HB 216) Explore cap ping available tax credits at maximum of $10 M per year.

**Target Population:**

Small Business and low income individuals

**Recommendation:**

A public/private recommendation could cover up to 6,000 uninsured individuals this proposal.

1. Year 2 & 3: Target employers with fewer than 5. Depending on the take-up rate, provide flexibility to increase credits for employers with 9 or less employees.
2. Year 3 & 4: Target employers with 9 or less employees.

**Support/Rationale:**

Tax relief proposals fill the coverage gap that exists between poor children and parents who are eligible for Medicaid and the Children's Health Insurance Plan (CHIP), as well as those who do not have access to or who cannot afford to purchase employer-sponsored insurance. The 2003 Montana Employer Survey, conducted by the University of Montana, identified that 56% of uninsured Montanans work for small businesses with ten or fewer employees. 48% of employers not currently offering health insurance coverage would do so with a tax credit of 50% or more. Further, close to sixty per cent of small businesses with ten or fewer employees do not offer health insurance. Eighty one percent of Montana firms not offering health insurance cite high premiums as the major reason why they do not offer insurance.

**Administrative Issues:**

Refundable tax credits utilize existing administrative systems and require less coordination and verification of coverage with employers. The Fiscal Notes for HB 204 and HB 216 identified at minimum increased workloads for the Department of Revenue and the State Auditor's Offices. (Credit payments, eligibility and outreach). The SHADAC Issue Brief #2 identifies additional advantages and disadvantages.

**Cost:**

The Fiscal Notes for HB 204 and HB 216 identified anticipated costs.

With the tax credit model, the State bears one-half of the cost. A Pilot Program identified in HB 204, based on a sample take-up projection of 12,700 individual credit and small group credit projected costs at $19 M for each year of the biennium.

HB 216 identified 38,997 income tax returns with combined incomes of less than 175% FPL. The fiscal note calculated the tax rate for eligibles that used the medical insurance deduction to be 3.65%. The net reduction in calendar revenue in FY 2004 was $20M and $41M in FY 2005.

Both legislative proposals would also require additional FTE within state government.

**Funding Sources:**

One of the intended uses of the revenue generated by a proposed tobacco tax increase is specifically targeted to new tax credits or to fund new program to assist small businesses with the costs of providing health insurance benefits to employees. Critical to the future of this proposal is the issue of sustainability for small businesses.

**Implementation:**

*Legislation would be required.

*Montana Department of Labor is encouraged to add questions to their survey of employers regarding health insurance, in order to track progress we have made in reducing the number of uninsured.

## II. B. Private Market Recommendation:

Expand health insurance options in the private market.

2. Explore the feasibility of reducing cost drivers such as mandated benefits, utilization and administrative complexity. Creative approaches should include consideration of basic benefit designs, care management programs, benefit limits and caps, cost sharing by consumers, and streamline of applications and paperwork related to healthcare coverage.

**Target Population:**

Unknown at this time.

**Recommendation:**

This private sector recommendation would require additional study and analysis. The 2002 Colorado Health Care Cost Study may provide comparative information. If the hypothesis is correct and alternatives can be identified, this recommendation may benefit small businesses that do not offer health insurance.

**Support/Rationale:**

As identified in the Montana Household and Employer Survey, eighty one percent of Montana firms not offering health insurance cite high premiums as the major reason why they do not offer insurance. Further, close to sixty per cent of small businesses with ten or fewer employees do not offer health insurance.

**Administrative Issues:**

Some of the current cost drivers are based on federal laws.

**Cost:**

Unknown

**Funding Sources:**

Pursue additional HRSA grant funds or request state funding via an interim legislative study.

**Implementation:**

*A Legislative Interim Study and/or other resources would be needed for a study/analysis of cost drivers.

## II. B. Private Market Recommendation:

Develop Legislative proposals that create more health insurance options to serve the private sector uninsured.

3. Pursue development of legislative proposals that encourage group sponsored health care plans like the currently available individual only plans such as Blue Care or the New West Bridge Plan.

### Target Population:

A private sector recommendation that would help address the uninsured in a number of categories: Young adults, especially those who are turning 19 and are no longer eligible for Medicaid or CHIP, Adults in the 19-26 year old category not enrolled in post-secondary schools and adults working for small businesses who do not offer health insurance.

### Support/Rationale:

With one in every five Montanan currently uninsured, there is value in the Legislature exploring other options in order to provide health care services for the uninsured.

Employers are very interested in an affordable option to traditional health insurance plans. While a limited benefit plan is not considered optimal, it offers a considerable improvement over the absence of health care coverage for thousands of individuals. Such a plan also provides a broader base for cost sharing across a group that is not currently participating.

The safety net that exists now to cover the uninsured places the cost on the shoulders of individuals obtaining care and providers. Under a limited plan design, cost may be modified by insurers who have the capability to direct care, offer care management and who may negotiate reimbursement on behalf of their covered members.

Currently there are only two programs in Montana which specifically address the uninsured:

- Blue Care, a product offered by Blue Cross Blue Shield, offers a low premium benefit for uninsured individuals and families. The basic benefit package includes primary care, emergency room, pharmacy and hospitalization. Maximum benefits are capped.
- The 2003 Legislative Session, in HB 384, provided avenues for a demonstration project to provide limited health care services to uninsured Montanans. The current demonstration project, sponsored by New West Health Plan, provides insurance to uninsured Montanans under the age of 65 and not on Medicare, who have been uninsured for the previous six months and live within a 30-mile radius of Billings or Helena. The provisions within HB 384 allow the demonstration project to exclude some of the services that are a mandated requirement of health insurance plans. The New West Health Plan includes access to primary and specialist care in the office setting, basic lab and x-ray, generic prescription medication, mental health and other outpatient therapies. It does not provide services for emergency room and inpatient hospitalization.

While enrollment is currently quite low, only 50% of the enrollees have utilized services in the first quarter. This demonstrates a cost sharing opportunity of such a plan.

### Administrative Issues:

Flexibility in Legislation, as evidenced by HB 384.

### Cost:

No state cost.

### Implementation:

*Legislation would be required for this private sector recommendation.

*The State Auditor's office will review and study the annual reports submitted by New West Health Plan regarding the Bridge Program, the pilot project created by the 2003 Legislative session.

*Legislation (HB 384) enabling plans such as New West's Bridge Plan sunsets in 2009.

## Section 3 - Requires Legislation and/or State Funding Recommendations

### III. Requires Legislation and/or State Funding Recommendation:

A Enroll those currently eligible:

1. for Medicaid
2. for the Children's Health Insurance Plan (CHIP) at or below 150% Federal Poverty Level.

**Target Population:**

Uninsured, eligible children for Medicaid and those children currently eligible for CHIP below 150% FPL. DPHHS has estimated that 7,000 children could be covered by Medicaid and 15,000 additional children by CHIP.

**Support/Rationale:**

Public-private sector recommendation

Covering the most needy has been a consistent theme identified by the various committees of the State Planning Grant. The Montana Household Survey findings identified approximately 22,000 children in Montana are uninsured and living in households with annual gross incomes below 150% FPL. The current CHIP eligibility income limit is at or below 150% FPL.

**Administrative Issues:**

The program is currently operational. Additional staff will be needed to address workload associated with increased enrollment.

**Cost:**

Assuming an 85% utilization, the cost to the State to cover those currently eligible for Medicaid would be $3.5 M and $4 M for CHIP. An annual cost to the State to insure a child under Medicaid is $590.35. Annual cost to the State to insure a child under CHIP is $311.60.

**Funding Sources:**

State and Federal dollars
Donations to CHIP program

**Implementation:**

*Legislative Recommendation:

-Request DPPHS address funding needs through HB 2 in order to assure general fund appropriations for the state share for Medicaid and CHIP.

*DPHHS:

- Funds for DPHHS staff and associated costs to develop and maintain outreach efforts to educate parents about the program.
- Document and track barriers for those who do not apply for programs for which they are eligible.
- Continue collaboration with Tribal Health and DPHHS to enroll Native Americans in Medicaid and/or CHIP if eligible.

## III. Requires Legislation and/or State Funding Recommendation:

B. Provide coverage for uninsured children up to 200% Federal Poverty Level.

1. Expand CHIP to cover children at 200% Federal Poverty Level.

   Expand CHIP in graduated increments:
   a. 165% FPL
   b. 185% FPL
   c. 200%FPL

2. Institute increased cost sharing for children between 151% - 200% FPL.

**Target Population:**

Uninsured, eligible children below 200% FPL.

Target number of uninsured individuals this proposal will address: 13,900, identified in the 2003 Montana Household Survey. If graduated increments are implemented in order to decrease the number of uninsured children, we would see the following number of children potentially served:

- Up to 165% FPL would include an additional 2,700 children
- Up to 185% FPL would include an additional 4,700 children
- Up to and including 200% FPL would include an additional 6,500 children
- A total target population of 13,900 children would be served.

In proposing an incremental approach to serving more children, it is the goal of the State Planning Grant to attain a 3% uninsured rate among Montana children.

**Support/Rationale:**

Public-private sector recommendation

The Montana Household Survey findings identified approximately 13,900 children in Montana who are uninsured and living in households with annual gross incomes between 151% and 200% FPL. The current CHIP income limit is 150% FPL.

**Administrative Issues:**

The program is currently operational. Additional staff will be needed to address workload associated with increased enrollment.

CHIP coverage cannot be expanded to children within this income range until all the children living at or below 150% FPL are covered.

**Cost:**

CHIP contracts with an insurance plan for medical benefits. Total cost per year per child for medical benefits, dental services, eyeglasses, and state administration is $1,639.99, of which the state share is $311.60

Assuming an 85% take-up rate, 11,815 children between 151% and 200% FPL would be covered. The total annual cost would be $19,360,082, of which the state share is $3,808,128.

**Recommendation:**

| | | (State Share) |
|---|---|---|
| Year 2 | Serve 2,295 up to 165% | Cost: $715,122 |
| Year 3 | Serve- 6,290 up to 185% | Cost: $1,959,964 |
| Year 4 | Serve 9,265 up to 200% | Cost: $2,886,974 |
| Year 5 | Serve 11,815 up to 200% | Cost: $3,681,532 |

Increased cost sharing: Cost sharing for this group can be increased up to a 5% of annual gross household income. Increased cost sharing would mitigate the premium for the medical benefit and the costs listed above would be slightly lower. Maximum annual cost sharing for each income group:

| | |
|---|---|
| 165% FPL | $702 ($58 per month) |
| 185% FPL | $772 ($64 per month) |
| 200% FPL | $865 ($72 per month) |

**Funding Sources:**

State and Federal dollars
Donations to CHIP program

**Implementation:**

*Legislative Recommendation:

- Request DPPHS address funding needs through HB 2 in order to assure general fund appropriations for the state share for CHIP.
- Request a change in statute to increase CHIP income level from a maximum of 150% FPL to 200% FPL.

*DPHHS:

- Implement administrative changes in order to serve uninsured children at determined Federal Poverty Level.
- Implement cost sharing, if approved. Note there is no cost sharing at 100% FPL. The cost sharing is limited to 5% of the gross family income. Co-payments currently exist for the children between 101-150% Federal Poverty Level.

## III. C. Recommendation:

Maintain or increase the Montana Comprehensive Health Association (MCHA) high-risk pool availability of coverage, recognizing MCHA is charged with serving as the access mechanism for Montanans with high-risk medical conditions through:

1. Ensuring enrollment for all those currently eligible
2. Maintaining or increase the low-income premium assistance state subsidy established by the 2003 Legislature.
3. Exploring the possibility of expanding the current premium assistance program for eligible individuals from 150% Federal Poverty Level to 200% Federal Poverty Level.
4. Continuing participation in the Trade Adjustment Assistance Act (TAA) and consider support for Trade Adjustment Assistance expansion.
   a. If an individual is TAA qualified, one can receive tax credits and participate in the portability pool.
   b. Additional TAA support is available through a federal grant for the entire MCHA, not just those who are eligible for TAA credit. MCHA, a current TAA grant recipient should apply for future grants as they become available.

### Target Population:

MCHA offers subsidized policies of individual insurance to eligible Montana residents who are considered uninsurable due to medical conditions or have lost coverage subject to the Health Insurance Portability and Accountability Act (HIPAA) and are eligible for HIPAA Portability coverage. Currently MCHA serves the following:

- The traditional plan covers over 1400 people
- The Portability plan covers over 1680 individuals.
- The MCHA premium assistance program serves more than 180 individuals. The MCHA premium assistance program provides an additional premium subsidy for persons with qualifying conditions and a family income at or below 150% FPL. The 2003 Legislature also qualified the MCHA Portability Plan as a coverage option for persons certified as eligible for the Trade Adjustment Act assistance (TAA), (see page 20).

It is difficult to predict the take-up if the program was expand to 200% FPL. It is also likely some individuals currently covered through MCHA would move to the additional premium assistance program if the income criteria was raised to 200% FPL.

Target number of uninsured individuals this proposal will address: 3,500 – 4,000 individuals

### Support/Rationale:

Public-private sector recommendation

Created by the 1985 Legislature, MCHA, Montana's high-risk pool provides access to health care coverage to Montanans, who are otherwise considered uninsurable due to existing medical conditions. If coverage were not offered to these individuals, providers may be faced with charity and uncompensated health care services. Individuals served by this program have been rejected for health insurance coverage or been offered a policy with a rider excluding a primary health condition. The 1997 Montana Legislature created a new MCHA plan to comply with the Health Insurance Portability and Accountability Act. This act requires that the individual who loses employer group coverage have guaranteed access to individual coverage with credit for preexisting medical conditions.

### Administrative Issues:

The MCHA Board directs the program and the plan administered by Blue Cross and Blue Shield of Montana.

**Cost and Funding Sources:**

Current legislative appropriation of $1,150,000 for the biennium helps with the funding of the low-income Premium Assistance program; together with federal HRSA grant funds.

Traditional and Portability coverage is currently funded through premiums paid by the program participants (roughly 60% of program costs) and assessments against all insured health premiums in Montana picking up the balance. MCHA was also awarded a federal Trade Adjustment Assistance Act (TAA) grant of $638,228 to help offset health care expenses in calendar year 2004.

As identified in the Montana Household Survey uninsured individuals can afford to pay low monthly premiums. When faced with pre-existing medical conditions and or having lost coverage, the premium cost is a major factor for most. The State Planning Grant recommends the MCHA Board consider a benefit redesign for low-income individuals at different levels of the Federal Poverty Level (FPL).

Aggregate cost of an additional 3000 individuals would be in excess of twenty million dollars for individuals not receiving the additional premium assistance. In that current premiums cover about 60% of costs that leaves about $8million to be covered elsewhere, a small portion of which would be assessment dollars. Since assessments are capped, additional funds would be needed.

**Implementation:**

*Legislature: 17-6-606 MCA: Continue subsidy of MCHA and the premium assistance, established by the 2003 Session. (The statute is referenced rather than HB 2 since it is a statutory allocation and as of July 1, 2005 some of the other allocations terminate. These dollars may need to be identified with the Governor's Executive Planning Process.)

*MCHA Board/State Auditor: Continue to pursue federal funding sources where applicable

- Ensure sustainability of current MCHA program.
- Continue to explore expansion of the MCHA assessment base to provide MCHA sustainability into the future.
- MHCA continue current outreach including requesting all insurance agents provide MCHA to those who do not qualify for other plans, public service announcements, Health Fairs etc.
- Identify a means to document current barriers regarding affordability of coverage.
- Continue to review and monitor the health status responses to the Behavioral Risk Factor Surveillance Survey (BRFSS) conducted annually by the Department of Public Health and Human Services (DPHHS) [these statistics may help identify approximate numbers of persons with health risk factors and/or pre-existing conditions.]
- Continue Annual Report to Legislature and State Auditor's Office regarding enrollment and access issues and to insure funding sources.

*Department of Labor:

- Develop and maintain outreach to potentially eligible persons
- Continue to pursue federal funding sources (i.e. TAA)

## III. D. Recommendation:

Explore a prescription benefit for those adults: Between the ages of 62-64, up to and including 200% Federal Poverty Level and who have applied for disability and have the two-year waiting period.

### Target Population:

Underinsured and Uninsured adults

Total number of Montanans between the ages of 62-64 is 22,684 (2000 Census Data). The assumption is that no more than half are at or below 200%FPL (11,342).

### Support/Rationale:

Public-private sector recommendation

The cost of prescription drugs is a significant cost driver. Nationwide prescription costs have been increasing as much as twenty to thirty percent per year. Moreover, prescription services may delay or obviate the need for inpatient services and thereby prevent more expensive care.

### Administrative Issues:

Legislative proposals were introduced in the 2003 Session. The eligibility requirements, as identified in SB 474 were complicated. The program would not go into effect until January 2005. Eligibility system enhancements would be required if this program was administered by DPHHS. SB 473, dependent upon approval of federal waivers, expanded the Medicaid prescription drug program. The fiscal note identified the average cost of a prescription at $49.67 in FY 2005.

### Cost:

The fiscal note of SB 474 identified that the required amount of state funding was undefined. The fiscal note of SB 473 identified state special revenue (generated from an application fee), state and federal dollars in order to establish and maintain the program.

### Funding Sources:

Based on past legislative history funds would include state general funds; state special revenue, federal funds and prescription rebate fees. In addition, one of the intended uses of the revenue generated by a proposed tobacco tax increase is specifically targeted to fund a state prescription drug program.

### Implementation:

*In the interim, until the program is funded, provide outreach regarding Patient Assistance programs offered by pharmaceutical companies and/prescription discount programs/cards. Use the Information and Assistance program within the ten Area Agencies on Aging.

*Explore the use of preferred drug lists as a way to control the high cost of drugs.

*Review, as identified by the Safety Net work group, the evidence based research (i.e. Oregon)

*As identified in the Health Literacy section, provide education and consultation on the wise use of prescriptions. (i.e. PharmAssist program)

*Review Rx programs offered in the District of Columbia, Idaho, Alaska, Indiana, Vermont, Minnesota, Maine and Hawaii.

*Request FDA approval for importation of drugs from Canada.

## IV. A. General Recommendation to Public Health Redesign Committee:

1. Address those currently eligible under existing programs that are not enrolled in Medicaid or CHIP (See Recommendation III A.)
   a. Document and track barriers for those who do not apply for programs for which they are eligible.
   b. Continue collaboration with existing groups to enroll Native Americans in Medicaid and/or CHIP, if eligible.
2. Expand CHIP to cover children at 200% Federal Poverty Level
   a. Expand CHIP in graduated increments (165%FPL, 185% FPL, 200% FPL). See Recommendation-III.B.
   b. Expand CHIP to cover children at 200% FPL.
   c. Institute increased cost sharing for children between 151% FPL and 200% FPL. See Recommendation III. B.
3. Administrative Issues: Maintain health care access for low-income Montanans by addressing Medicaid reimbursement and streamlining, where possible, administrative requirements.

### Target Population:

1. Uninsured, eligible children below 150% FPL for Medicaid and those currently eligible for CHIP below 150% FPL is estimated to be 22,000 children.
2. There are approximately 13,900 uninsured children, between 150% FPL and 200% FPL identified in the 2003 Montana Household survey. If graduated increments are implemented in order to decrease the number of uninsured children, we would see the following numbers of children potentially served:

   - Up to 165 % FPL would include an additional 2,700 children
   - Up to 185% FPL would include an additional 4,700 children
   - Up to and including 200% FPL would include an additional 6,500 children
   - A total target population of 13, 900 children would be served.

### Support/Rationale:

Public-private sector recommendation
Covering the most needy has been a consistent theme identified by the committees of the State Planning Grant.

### Administrative Issues:

The program is currently operational. Additional staff may be needed to address increased volume associated with application process etc.

### Cost:

1. The cost to cover those currently eligible for Medicaid would be $3.5M and $4M for CHIP.
2. Assuming an 85% take-up rate, 11,815 children between 151% FPL and 200% FPL would be covered. The total annual cost would be $19,360,082, of which the state share is $3,808,128.

### Funding Sources:

State and Federal dollars
Donations to CHIP program

### Implementation Recommendations:

Legislative Recommendation:
Request DPPHS address funding needs through HB 2 in order to assure general fund appropriations for the state share for CHIP.
Request a change in statute to increase CHIP income level from a maximum of 150% FPL to 200% FPL.

Recommend DPHHS continue to pursue waiver options. The waiver could carve out dollars through refinancing to specifically address outreach efforts, which would result in increased enrollment in Medicaid and/or CHIP.

## IV. B. Waiver Consideration for consideration by the Public Health Redesign Committee:

1. Insure parents/guardians of publicly insured children with the following considerations:
   a. At minimum, insure parents/guardians at or below 100% FPL have access to health insurance coverage.
   b. Consider premium assistance program or a basic medical plan, which may have limits, exclusions and/or capped coverage for certain services.
   c. Explore a modified, self-directed concept, (similar to the Home and Community Based Waiver), which provides the consumer with capped basic benefits, where the consumer shares an increasing responsibility for their own health care. Consider a plan, using a debit card that is front-loaded, with consumer knowledge of the balance. Expand Medicaid to cover parents/guardians between 101 – 150% FPL.
2. Expand Medicaid to cover parents/guardians between 101% FPL and 150% FPL.
   a. Provide a premium assistance program or a basic medical plan, which may have limits, exclusions and/or capped coverage for certain services.
   b. Explore a modified, self-directed concept, (similar to the Home and Community Based Waiver), which provides the consumer with capped basic benefits, where the consumer shares an increasing responsibility for their own health care. Consider a plan, using a debit card that is front-loaded, with consumer knowledge of the balance. Expand Medicaid to cover parents/guardians between 101 – 150% FPL.

3. Explore options to provide coverage to Mental Health Service Plan recipients and/or low income working adults.
   a. Consider premium assistance program or a basic medical plan, which may have limits, exclusions and/or capped coverage for certain services.
   b. Explore a modified, self-directed concept, (similar to the Home and Community Based Waiver), which provides the consumer with capped basic benefits, where the consumer shares an increasing responsibility for their own health care. Consider a plan, using a debit card that is front-loaded, with consumer knowledge of the balance. Expand Medicaid to cover parents/guardians between 101 – 150% FPL.

**Target Population:**

- The SPG Coverage Options Committee recommends that parents at 150% FPL of publicly insured children, at minimum, covered.
- Based on the March 2004 enrollment of 10, 770 children in CHIP, there are 5, 385 families with children covered by the CHIP program. Statistics maintained by the Montana CHIP program indicates 6,998 parents are uninsured or 76% are uninsured. Health insurance statistics regarding parents of Medicaid children are not available.
- 76% of the parents of CHIP children are between the ages of 26-49. The Montana Household survey identifies an uninsured rate of 38% for those between the ages of 19 and 26 and 24% uninsured rate for those between the ages of 26-49. Providing health care to parents would help reduce the uninsured rate in Montana.
- The Mental Health Services Plan serves over 4,000 individuals annually. At a minimum, at least 90% of these individuals do not have health insurance.
- The waiver proposal would need to include a determination of the populations to include in the waiver, the implementation date and the coverage benefits offered.

**Support/Rationale:**

Public-private sector recommendation

Based on the 2003 Montana Household Survey, statistics indicated that although 70% of the parents are employed, only 7% have employer-sponsored health insurance. The policy implication deducted from this

information would indicate that no single approach would be effective in providing coverage for parents. Insuring parents, however, has been determined to be a positive strategy because the absence of health insurance can have serious consequences for the entire family. National studies and analysis, as identified in the Montana Issue Brief, reinforces that increasing access to health insurance would keep working parents healthy, plus assure their children would access on-going health care and preventive services as needed.

The development of the self-directed concept improves access, reduces bureaucratic complexities and promotes health literacy.

**Cost:**

DPHHS identified cost projections in the document following this recommendation. The modeling options presented by DPHHS include comparable health insurance products.

**Administrative Issues:**

Baseline information has been identified by the State Planning Grant has been beneficial. DPHHS will need to determine if they move forward through the HIFA waiver option (and determine if there is a full benefit or a limited benefit offered to parents).

**Funding Sources:**

State and Federal dollars
Through a HIFA waiver if pursued and granted

**Implementation:**

Recommend DPHHS continue to pursue waiver options. Through the waiver, a benefit design will need to be identified. Moreover, given the five year term of the waiver, provisions could be made to provide an employer premium assistance program at some point during the life of the waiver.

Legislative approval and an associated appropriation will be necessary in order to pursue the waiver option.

# Appendix A

## Summary of Efforts to Reduce Montana's Uninsured

# Summary of Efforts to Reduce Montana's Uninsured

### 1991 – Limited Benefit Disability Insurance

Legislative proposal to allow marketing of a basic benefit package to uninsured employer groups. As an incentive, a tax credit was proposed for up to ten employees with a graduated credit of up to $25 if the employer pays at least 50% of the health insurance cost. Basic plan provides maternity and newborn, well-child up to age two, a limited psychiatric and substance abuse benefit and hospital services. This was also a pay-or-play proposal, which did not make it, plus four new mandates and three health insurance regulatory expansions.

### 1993 - Montana Health Care Authority (HCA)

Legislative mandate to develop a comprehensive statewide health care reform strategy to provide all Montanans with improved access to high quality, affordable health care. The HCA was required to submit a single payer plan and a regulated multiple-payer system. A third alternative, a market-based sequential health care reform package was added. Due to financial constraints and lack of political consensus, plan was not funded.

- SB 285 Small Group Reform
  In addition to creation of the Health Care Authority, SB 285 also instituted the following small group reform provisions: establishment of classes of business with certain restrictions placed on rating; reasonable disclosure; guaranteed renewal except for premium non-payment; establishment of a minimum of two plans - a basic and a standard; limits preexisting waiting periods; regulates enrollment uniformity and contribution participation requirements; establishes small employer carrier reinsurance program.

### 1995 – Health Care Advisory Council (HCAC)

Replaces Health Care Authority. The Legislature charged the HCAC with monitoring and evaluating incremental and market-based approaches for health care reform.

- Health Information Network
  Legislature directed the development of a central database of healthcare resource, cost and quality information to increase access, promote cost containment and improve quality. The 1997 Legislature did not fund continuation of either of these projects.
- Group Purchasing Cooperative
  Legislatively authorized. Only one purchasing pool has been formed and its functions have changed considerably over time.
- Caring Program for Children
  Legislature provided state funding for this 1992-public/private partnership with Blue Cross Blue Shield of Montana, which targets low-income uninsured children.
- Mental Health Access Program
  Legislature authorized state funding for mental health services for non-Medicaid low-income individuals with serious mental illnesses/children with emotional disturbances.
- Small Group Reform, round II and the Small Employer Health Insurance Availability Act, Individual Market Reform
  Comparability provisions added; Uniform Benefit Plan, a lower-cost, catastrophic plan added; clarification that association plans must comply with guarantee issue; portability of preexisting waiting period carried to individual coverage. MCHA benefits expanded.
- Medicaid Managed Care
  Allowed a new category of licensure for managed care plans called Managed Care Community Networks that could be established by providers only.
- Premium Deductibility
  Allowed individual income tax deduction for 1/2 of premium payments for health insurance.
- Medical Savings Accounts
  Tax exemption for contributions up to $3000 deposited into a MSA Account.

**1997 – Managed Care Network Adequacy and Quality Assurance Act**
Legislative initiative to protect the rights of individuals enrolled in managed care plans. The Act improved access to emergency services and set standards for network adequacy and quality assurance, which, to date, are rare throughout the United States.

- **Montana HIPAA Implementation**
  All group business – prevention of "job lock", no discrimination on health status; preexisting condition look-back 6 months, credit for prior creditable coverage, small group reforms expanded to groups of 2 – 50; MCHA expansion for Portability – addition of coverage availability.

- **Premium Deductibility moved to 100%, MSAs amended and six additional insurance mandates or** regulatory provisions applied
- **1999 – Children's Health Insurance Plan (CHIP)** – Legislature approved funding for CHIP to address the increasing problem of low-income uninsured children.
- **Health Care Advisory Council** – was re-authorized in 2000 and the Council chose to prioritize their efforts towards the rising number of uninsured Montanans. DPHHS and the HCAC requested technical assistance from the State Coverage Initiative Program. These efforts resulted in the development of a **White Paper titled "Strategies for Improving Access to Health Care Coverage".**

2000 –
DPHHS implements several public/private programs to address the rising number of Montanans who were eligible for publicly funded insurance programs but were not enrolled.

**2001 – Joint Subcommittee on Health Care and Health Insurance (SJR 22)**
Legislature authorized the study of health care and health insurance costs and asked for recommendations for the 2003 Legislative session.

- **Montana Comprehensive Health Association (MCHA)** – Legislative authority to 1) established MCHA and a sliding scale premium for MCHA eligible persons with income less than 150% of FPL. Federal funding was received to implement this demonstration project. 2) Second bill required the Insurance Commissioner to set up a study committee to recommend a new financing system for MCHA.
- **Eight Community Roundtable Discussions on Affordable Health Care Coverage** – Montana's Insurance Commissioner held a series of eight community meetings to solicit comment on strategies to expand access to affordable health care.
- **Governor's Health Care Manpower Shortage Task Force** – Addressed hospitals' and health care communities concerns re: professional shortages (i.e. nursing, medical technicians such as lab techs, dentists, etc)
- **Governor's/Attorney General's Substance Abuse Task Force**
- **Unveiling of Blue Care** – a private initiative among three hospitals with a fourth joining immediately, three large physician groups and Blue Cross Blue Shield to provide a basic, lower-cost health plan to uninsured, lower-income Montanans through significant financial arrangements by Montana's health care community.

**2002 - Governor's Health Care Summit**
Montana's Governor invited Congressional Delegation, Legislators, public policy officials, and representatives from the health care, business, advocacy and insurance communities to comment on federal/state proposals, offer ideas to address Montana's uninsured and high cost/access to health care.

- **HRSA State Planning Grant received in order to develop a plan to address uninsured.**

**2003 - HB 204 The Montana Health Care Affordability Act**
The 2003 legislature considered this bill to significantly expand coverage to the uninsured. The bill included substantial advanceable, refundable tax credits for small business and low-income individuals, state matching funds to double the CHIP program and increase eligibility to 175%, prevent cuts to Medicaid coverage, and provide assistance to seniors who lack prescription drug coverage. The proposal was to be funded with $1.50 increase in the cigarette tax. Over 40 organizations and individuals supported the proposal. The bill died in the House Tax Committee.

- **HB 216 – Tax Credit for Small Businesses and Individuals Pilot.** The 2003 Legislature, based on a recommendation from the SJR 22 Committee, considered a bill to allow advanceable, refundable tax credits to small businesses and lower-income individuals. Died in House Tax Committee.
- **HB 104 – Revise laws for insurance purchasing pools.** Lowered the number of eligible individuals needed to form a purchasing pool from 1000 to 51.
- **HB 481 – Hospital Bed Utilization Fee.** Allows leverage of a state bed utilization fee to increase federal dollars for Medicaid payments, decreasing to a degree the cost-shift from Medicaid to private pay patients.
- **HB 302 and SB 259 – Statewide School Health Pool Proposals.** Both proposals made it through at least one house, but neither was finalized.
- **HB 384 Limited health benefit plans for uninsured individuals** Adopted by the legislature, this bill allows health insurers to conduct demonstration projects issuing limited benefit plans, including a plan covering only outpatient care.
- **SB 473 Health Montana** will allow DPHHS to apply for a Medicaid waiver to provide discounts on the purchase of prescription drugs for Montanans who lack drug insurance coverage and are under 200% of the federal poverty level.
- **First state funding to subsidize premiums for low-income individuals buying MCHA high-risk pool coverage.** In response to I-146, the legislature appropriated $1,350,000 for the biennium to the MCHA to continue the premium subsidy program begun in 2002 through a federal grant.

# Appendix B

## Strategic Plan Timeline

# Strategic Plan

| Category | Strategy | | Type of Coverage | Range served | Cost | Population | Legislation | Waiver | Feasibility | Year |
|---|---|---|---|---|---|---|---|---|---|---|
| I | A | | Association Plan-purchasing pool | # served to be identified | No state $ | Like business | already exists | N | Short Term | 2 |
| I | B-1 | | Policies & Procedures for Higher Ed proof of insurance | Young adults 19-40 | minimal | 5,000 young adults | None needed | N | Short Term | 2 |
| I | C | | Health Literacy | all Montanans | unknown | all Montanans | None needed | N | Ongoing | 2 |
| I | C-1 | | Health Promotion | all Montanans | unknown | all Montanans | None needed | N | Short Term/Ongoing | 2 |
| I | C-2 | | Preventative health curriculum | students | unknown | all Montanans | None needed | N | Short Term/Ongoing | 2 |
| II | A | | Safety Net | | | | | | | |
| II | A-1 | | Safety Net - Start-up for grants | Rural Montana | $50,000 | 20,000 | Yes (App) | N | Short Term | 2 |
| II | A-2 | | Safety Net - 50-50 State Community Match | Rural Montana | $25,000 | 20,000 | Yes (App) | N | Short Term | 2 |
| II | B-1 | | Tax Credits | small business low-income families | Revenue reduction | 6000 uninsured | Yes | N | Short Term | 2 |
| II | B-2 | | Explore reduction of cost drivers | small business low-income families | unknown | unk | Yes | N | Short Term | 3 |
| II | B-3 | | Develop proposals to encourage employee sponsored plans | uninsured | no state | to be determined | Yes | N | Short Term | 2 |
| III | A-1 | | Enroll Currently Eligible Medicaid | MT children 0-18 | $3.5M | 7,000 | Y HB2 | N | Short Term | 2 |
| III | A-2 | | Enroll Currently Eligible CHIP | 0-18 | $4M | 15,000 | Y HB2 | N | Short Term | 2 |
| III | B-1 | | Expand CHIP | 0-18 | $3M | 14,000 | Y HB2 | N | Long Term | 4 |
| III | B-1 | a | to 165% FPL-Year 2 | 0-18 | $715,122 | 2,295 | Y HB2 | N | Long Term | 5 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| III | B-1 | b | to 185% FPL-Year 3 | 0-18 | $1.96M | 6,290 | Y HB2 | N | Long Term | 6 |
| III | B-1 | c | to 200% FPL-Year 4 | 0-18 | $2.88M | 9,265 | Y HB2 | N | Long Term | 7 |
| III | B-1 | d | to 200% FPL-Year 5 | 0-18 | $3.68M | 11,815 | Y HB2 | N | Long Term | 8 |
| III | B-2 | | Institute cost sharing 151%-200%FPL | 0-18 | 0 | 4,000 | Y | N | Long Term | 4 |
| III | C | | Maintain or increase MCHA | 19-62 | | 4,000 | Y | N | Short Term | 3 |
| III | C-1 | | Ensure enrollment of all currently eligible | 19-62 year olds | grant $ | 4,000 | Y | N | Short Term/Ongoing | 2 |
| III | C-2 | | Maintain or increase low income premium assistance amount | 19-62 | $1.5 M | 200 | Y | N | Short Term | 3 |
| III | C-3 | | Increase premium assistance to 200% FPL | 19-62 | ? | 200 | Y | N | Long Term | 4 |
| III | C-4 | | Continue participation in TAA | 19-62 | fed grant $ | | N | N | Short Term | 2 |
| III | D | | Rx benefit for 62-64 & disabled | disabled adults | unknown | 11,342 | Y | Possibly | Long Term | 5 |
| IV | A-1 | | Address currently eligible for M/CHIP | 0-18 | $7.5M | 22,000 | Y | Possibly | Short Term | 2-4 |
| IV | A-2 | | Expand CHIP to 200% FPL | 0-18 | $3M | 14,000 | Y | Y | Long Term | 5 |
| IV | A-2 | a | incrementally by FPL | see III B | see III B | see III B | Y | Y | Long Term | 6 |
| IV | A-2 | b | expand CHIP to 200% FPL | 0-18 | $3M | 14,000 | Y | Y | Long Term | 6 |
| IV | A-2 | c | Institute Cost Sharing | 0-18 | 0 | 14,000 | Y | Y | Long Term | 7 |
| IV | B | | Insure parents/guardians of publicly insured children | 19-50 year olds | | | | | Long Term | WD |
| IV | B-1 | a | Insure parents/guardians at or below 100% FPL | 19-50 year olds | $1M-Waiver | 11,813 | Y | Y | Long Term | WD |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| IV | B-1 | b | Premium Assistance or basic medical plan | 19-50 year olds | $3M-Waiver | #TBD | Y | Y | Long Term | WD |
| IV | B-1 | c | Self-directed concept | 19-50 year olds | Waiver | #TBD | Y | Y | Long Term | WD |
| IV | B-2 | | Expand Medicaid to cover parents/ guardians between 101-150% FPL. | 19-50 year olds | Waiver | 7,000 | Y | Y | Long Term | WD |
| IV | B-2 | a | Premium Assistance or basic medical plan | 19-62 year olds | Waiver | #TBD | Y | Y | Long Term | WD |
| IV | B-2 | b | Self Directed | 19-62 year olds | Waiver | #TBD. | Y | Y | Long Term | WD |
| IV | B-3 | | Explore coverage for Mental Health Service Plan recipients and/or low income working adults. | 19-50 year olds | Waiver | 2,000/month 4000/year | Y | Y | Long Term | WD |
| IV | B-3 | a | Premium Assistance or basic medical which may have limits | 19-50 year olds | Waiver | #TBD | Y | Y | Long Term | WD |
| IV | B-3 | b | Self directed concept | 19-50 year olds | Waiver | #TBD | Y | Y | Long Term | WD |

- TBD - To Be Determined
- WD - Waiver Dependent

# Appendix C

**Summary of Coverage Options Recommendations**
**Public Sector, Employer and Individual**

# Summary of Coverage Options Recommendations

## I. No Significant Fiscal Impact to the State of Montana:

A. Encourage Associations and groups to explore the benefits of purchasing pools, given the legislative changes made in the 2003 Legislative session.

B. University System:

1. **Recommend the Commissioner of Higher Education, Board of Regents and the University/ Community College system develop consistent internal policies and procedures to require proof of existing insurance coverage (parents or employers) or require student to purchase health insurance offered through the University System.**

C. Health Literacy: Educate the public in the benefits of health insurance coverage by promoting health literacy and the value of maintaining one's health.

1. Improve health promotion with consumers and employers (i.e. wise pharmacy)
2. Promote preventive health curriculums within the education system. (Consumer Education, General Life Skills, Driver's education, etc.)

## II. Requires new state legislation and/or new state dollars

A. Safety Net: Recognize and support the Safety Net (Community Health Centers, FQHC, Urban Indian Clinics etc.) as a vital component of the health care delivery system. Support recommendations to enhance the Safety Net's ability to operate throughout the state. Recommendation includes a request for funding.

B. Private Market: Sustain and expand health insurance options in the private market.

1. Continue to pursue tax credits options for low-income individuals with family incomes less than 175% FPL and employers with fewer than 5 employees who do not have any employees earning more than $150,000 per year. Continue to pursue tax credit incentives at 50% employer level and for individuals at 175% Federal Poverty Level (as introduced in 2003 Legislative Session: HB 204 and HB 216) Explore capping available tax credits at maximum of $10 M per year.
2. Explore the feasibility of reducing cost drivers such as mandated benefits, utilization and administrative complexities. Creative approaches should include consideration of basic benefit designs, care management programs, benefit limits and caps, cost sharing by consumers, and streamline of applications and paperwork related to healthcare coverage.
3. Pursue development of legislative proposals that encourage employer sponsored health care plans like the currently available individual only plans such as Blue Care or the New West Bridge Plan.

## III. Requires Legislation and/or a State Funding mechanism

A. Enroll children currently eligible for Medicaid and CHIP

1. Medicaid
2. CHIP (at or below 150% Federal Poverty Level (FPL)

B. Expand CHIP: Provide CHIP coverage for uninsured children up to 200% FPL (Federal Poverty Level.)

1. Expand CHIP to cover children at 200% Federal Poverty Level.
    a. Expand CHIP in graduated increments (165% FPL, 185%, 200 %)
2. Institute increased cost sharing for children between 151-% - 200% Federal Poverty Level.

C. MCHA: Maintain or increase the Montana Comprehensive Health Association (MCHA) high-risk pool availability of coverage through:

1. Ensure enrollment for those currently eligible.

2. Maintain or increase the low-income premium assistance state subsidy established by the 2003 Legislature.
3. Explore the possibility of expanding the current premium assistance program for eligible individuals from 150% Federal Poverty Level to 200% Federal Poverty Level.
4. Continue participation in the Trade Adjustment Assistance (TAA) and consider support for Trade Adjustment Assistance expansion.
    a. If an individual is TAA qualified, one can receive tax credits and participate in the portability pool.
    b. Additional TAA support is available through a federal grant for the entire MCHA, not just those who are eligible for TAA credit. MCHA, a current TAA grant recipient should apply for future grants as they become available.

D. Prescription Benefit: Explore a prescription benefit for those adults:
1. Between the ages of 62-64, up to and including 200% FPL and
2. Who have applied for disability and have the two-year waiting period.

## IV. Public Health Redesign Committee Recommendations

A. General Recommendations:

1. Address those currently eligible under existing programs that are not enrolled in Medicaid or CHIP.
    a. Document and track barriers for those who do not apply for programs for which they are eligible.
    b. Continue collaboration with existing groups to enroll Native Americans in Medicaid and/or CHIP if eligible.
    c. Resume outreach to potentially eligible Medicaid and CHIP children

2. Expand CHIP to cover children at 200% FPL.
    a. Expand CHIP in graduated increments (165% FPL, 185% FPL)
    b. Expand CHIP to cover children at 200% Federal Poverty Level.
    c. Institute increased cost sharing for children between 151-% - 200% Federal Poverty Level.

3. Administrative Issues: Maintain health care access for low-income Montanans by addressing Medicaid reimbursement and streamlining, where possible administrative requirements.

B. Waiver Considerations:

[Addressing the groups identified below would target a large number of uninsured parents in the 19-50 year old age category; parents who work for small businesses and/or parents who are unable to purchase coverage through their employer.]

1. Insure parents/guardians of publicly insured children with the following considerations:
    a. At minimum, insure parents/guardians at or below 100% FPL.
    b. Consider premium assistance program or a basic medical plan, which may have limits, exclusions and/or capped coverage for certain services.
    c. Explore a modified self-directed concept (similar to the Home & Community Based Waiver), which provides the consumer with capped basic benefits, where the consumer shares an increasing responsibility for there own health care. Consider a plan, using a debit card that is up front loaded, with consumer knowledge of balance.

2. Expand Medicaid to cover parents/guardians between 101-150% FPL.
    a. Provide a premium assistance program or a basic medical plan, which may have limits, exclusions and/or capped coverage for certain services.

b. Explore a modified self-directed concept (similar to the Home & Community Based Waiver), which provides the consumer with capped basic benefits, where the consumer shares an increasing responsibility for there own health care. Consider a plan, using a debit card that is up front loaded, with consumer knowledge of balance.

3. Explore options to provide coverage to Mental Health Service Plan recipients and/or low income working adults:

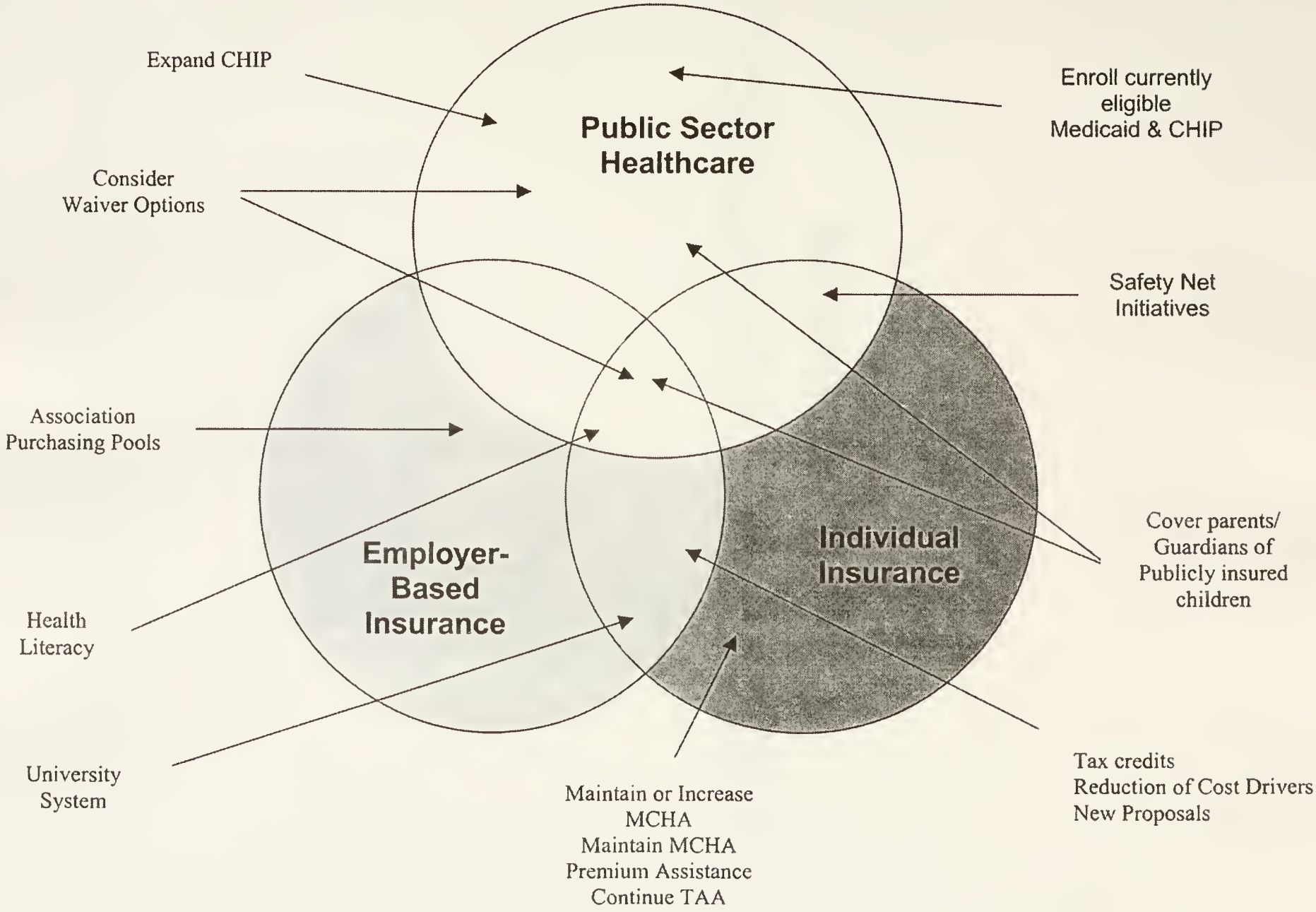
a. Provide a premium assistance program or a basic medical plan, which may have limits, exclusions and/or capped coverage for certain services.

Explore a modified self-directed concept (similar to the Home & Community Based Waiver), which provides the consumer with capped basic benefits, where the consumer shares an increasing responsibility for there own health care. Consider a plan, using a debit card that is up front loaded, with consumer knowledge

# Appendix D

## Coverage Option Map
## Montana Strategies to Increase Coverage

# Montana Strategies to Increase Coverage



# Appendix E

**Final Report: Household Survey and Employers Survey Findings about Health Insurance Coverage in Montana**

# Final Report

## Household Survey and Employer Survey Findings about Health Insurance Coverage in Montana

## February 2004

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This research project was conducted
for the Montana Statewide Study of the Uninsured
State Planning Grant
The Department of Public Health and Human Services

Submitted to the Department of Public Health and Human Services
February 2004 in partial fulfillment of Contract #03-07-1-05-003-0
State Planning Grant

MONTANA
Department of Public Health & Human Services

Bureau of Business & Economic Research

The University of Montana
MISSOULA

# Contributions and Acknowledgements

This report was written by Steve Seninger with assistance from Jim Sylvester, Daphne Herling, and John Baldridge of the Bureau of Business and Economic Research, University of Montana-Missoula Campus. Barbara Wainwright, Shannon Furniss, and Amy Joyner provided editorial assistance.

The authors would like to thank Maggie Bullock and Kelly Moorse of the Montana Department of Public Health and Human Services for their support and assistance throughout the project. The Governor's Steering Committee on the State Planning Grant, chaired by Tanya Ask and Gail Gray, provided guidance and positive feedback on the survey, key informant, and focus group components of the project. Jean Branscum, policy advisor to the Montana Office of the Governor, made a number of helpful contributions to the project and coordinated project briefings and survey findings with Governor Judy Martz.

The Research and Analysis Bureau, Montana Department of Labor and Industry, provided data and assistance when developing the employer sample. The research team would also like to acknowledge the technical assistance and experience with other state projects from the State Health Access Data Assistance Center (SHADAC), University of Minnesota.

This project was supported by a grant from the Health Resources and Services Administration, U.S. Department of Health and Human Services.

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# Executive Summary

Montana has historically had one of the higher rates of uninsurance in the nation. Depending on the source of data, current estimates of uninsurance in Montana range from 14 percent of the population to 19 percent. This report presents findings from the 2003 Montana Household Survey and the Montana Employer Survey, the largest and most comprehensive surveys on health insurance that have been conducted in Montana to date. Consistent with earlier studies, the Household survey finds a relatively high overall 19 percent of Montana's population without health insurance, a rate representing 173,000 Montanans who were uninsured at the time of the survey.

Because of the way the 2003 Household Survey was designed, the state is able for the first time to make detailed estimates of uninsurance rates for various population groups within the state, such as rates by age, race and ethnicity. Although the overall rate of uninsurance in Montana is high, the survey finds substantial variation in uninsurance rates within various population groups including:

- Young adults, particularly between the ages of 19 and 25, were more than twice as likely to be uninsured than the general population.
- Montana's American Indian populations experience uninsurance at much higher rates , which were two times higher than the statewide average and represented about 24,000 American Indians within the 173,000 Montanans without health insurance.
- Insurance status also varies by income level, with Montanans who have incomes below the federal poverty level being about two times more likely to be uninsured than the statewide average.
- The Children's Health Insurance Program is an important source of healthcare access to 10,700 Montana children, a number that will go up with increased state and federal funding aimed at adding 1,300 more low-income children to the program.

A detailed analysis of the 173,000 uninsured Montanans shows the number of persons in different groups and socio-economic levels representing the state's uninsured population. A profile of Montana's uninsured shows that they:

- Are white (86 percent);
- Are adults over 25 years of age (67 percent);
- Have a high school degree or higher (92 percent);
- Have income levels more than twice the poverty level (45 percent);
- Are employed (77 percent); and,
- Are self-employed or work for firms with 10 or fewer employees (60 percent).

The 2003 Montana Household Survey asked specific questions about other issues of interest to policy makers, such as medical debt, insurance affordability, and individual insurance policies. Findings include:

- Uninsured persons were more than three times as likely to have medical debt (21 percent) compared to those with health insurance (7 percent);
- Average medical debt was $2,500 or higher and represented as much as 16 percent of household income for persons without health insurance;
- Being uninsured is not voluntary, with 90 percent of the uninsured reporting being unable to buy health insurance after paying for food, clothing, and shelter;
- Uninsured persons can afford to pay low monthly premiums, averaging about $96 per month;
- Montana's uninsured did have coverage in the past, with only 20 percent reporting no previous health insurance;
- High average deductibles of more than $3,000 for persons with individual insurance policies; and,
- Individual insurance policies take a big bite of monthly household income ranging from 21 percent for people below twice the poverty level and 8 percent for persons more than two times (200 percent) above the poverty level.

A key objective of the Employer Survey was to fill in gaps in our knowledge about Montana business offering of health insurance to their employees. Major findings from the Montana Employer Survey include:

- Over 40 percent of small firms with 10 or fewer employees offer health insurance;
- One third of small firms offering health insurance offer it to all employees, typically for employees working 30 hours or more per week;
- More than 90 percent of large firms with 100 employees offer health insurance;
- Only half of large firms offering health insurance offer it to all employees;
- For the 81 percent of Montana firms not offering health insurance, high premiums are cited as the major reason why they do not offer insurance;
- When asked why their eligible employees did not use the health insurance coverage offered, 28 percent of the employers responding to this question cited high premium costs and the affordability of insurance as the major reason;
- More than 80 percent of employers cite higher prices for hospital care, prescription drugs, physician care, and malpractice insurance as major reasons for health insurance premium increases;
- Sixty-seven percent of firms not offering insurance thought they would provide insurance under a tax credit policy; and,
- More than 40 percent of firms not offering insurance indicated they would 'absolutely' participate in a small business purchasing pool.

# Chapter 1: Introduction

Montana has historically had one of the highest rates of uninsurance in the nation. Depending on the source of data, current estimates of uninsurance in Montana range from 14 percent of the population to 19 percent. In surveys that allow for cross-state and national comparisons of uninsured rates, Montana has always ranked near the bottom in rates of health insurance coverage.

In the summer of 2002, the Montana Department of Public Health and Human Services was awarded a grant from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services to study the issue of uninsurance in Montana. HRSA's State Planning Grant program exists to provide support to states to conduct research and analysis of insurance coverage issues, and to provide policy options for reducing uninsurance. Montana was one of several states originally awarded grants under this program in the 2002 funding round. Although the state already had some knowledge about its uninsured population from national estimates, the HRSA grant provided an opportunity to fill in gaps in the State's knowledge about the uninsured. In particular, little detail was previously known about disparities in health insurance status by race and ethnicity, and there was little information about how health insurance status varies by age and income.

From Fall 2002 through Summer 2003, the Montana Department of Public Health and Human Services, in collaboration with the University of Montana's Bureau of Business and Economic Research, conducted two surveys, the 2003 Montana Household Survey and the Montana Employer Survey. These surveys were designed to help fill in some major gaps in the state's knowledge about its uninsured population. Together with several other study components, the Household and Employer Surveys have contributed to a deeper understanding of how health insurance coverage varies among different population groups in Montana, what barriers exist that prevent the uninsured from getting coverage, and how this affects their ability to access the health care system.

This report details the findings from the 2003 Montana Household Survey and the Montana Employer Survey. It presents findings on rates of uninsurance in Montana and the characteristics of the uninsured; it also examines variations in uninsurance rates and characteristics of the uninsured by age, race and ethnicity, urban and rural areas, and income level.

## Household Survey Methods

The 2003 Montana Household Survey was a stratified random digit dial telephone survey. The data were collected by the Survey Research Center at The University of Montana-Missoula, Bureau of Business and Economic Research from December 2002 to May 2003. One person in each household was randomly selected as a target for the survey; if this person was a child, then an adult was asked to respond on behalf of the child. In order to fulfill the study goals of getting better information on health insurance disparities by race/ethnicity and region, some geographic areas of the state were sampled with higher probability than other areas. In analyzing the data, statistical weights are used in order to generalize the results to the entire population of the state. The appendix to this report contains more detailed information on survey methods and the development of the statistical weights.

A total of 5,074 interviews were completed. The overall response rate to the 2003 Household Survey was 75 percent. The sample size includes all age groups and is much larger than other samples used for estimating the state's uninsured rate such as the Census Population survey (approximately 1,500 households) or the Behavioral Risk Factor Survey (3,100 Montana adults) conducted by the Centers for Disease Control.

Like all surveys, the findings from the 2003 Household Survey have a margin of error associated with them. This margin of error reflects the fact that there is always uncertainty involved in the process of creating statewide estimates from a representative sample of the population. In other words, although estimates from the survey data may appear to be different, the difference sometimes falls within the margin of error for the estimates and therefore cannot be considered to be statistically significant.

## Related Projects

While the 2003 household telephone survey has added significantly to the state's knowledge about its uninsured population, it is only one of a number of studies that have been conducted under the HRSA grant. These other studies include:

**Employer Survey:** Many Montanans get their health insurance through an employer, so the private employment-based health insurance system is of key importance to studies of health insurance coverage. With health insurance premiums rising at or near double-digit rates for the past several years, it is important to monitor the impact that premium increases are having on the availability and affordability of employer-based coverage. With this in mind, a stratified random digit dial telephone survey on a representative sample of 539 Montana employers was conducted. The survey was designed to determine how cost increases have affected private coverage and what other factors affect the offering of health insurance by Montana employers to their workers.

**Key Informant Interviews:** During the spring and summer of 2003, Daphne Herling, director of community research, from the University of Montana Bureau of Business and Economic Research conducted a series of 30 interviews statewide with "key informants" who were professionals who have contact with many people who are either uninsured or at high risk of becoming uninsured. The key informants included health care providers, clinic and hospital administrators, private businesses, farmers and rancher organizations, insurance companies,community leaders, and advocates.

**Focus Groups:** Focus groups on health insurance were conducted among four consumer groups and two groups of employers by two professional qualitative data researchers from Montana State University-Billings and the University of Montana-Missoula. One particular goal of the consumer focus groups was to obtain qualitative information about attitudes toward, problems with and knowledge of health insurance that is difficult to obtain in a telephone survey.

The consumer focus groups were geographically representative of rural and urban Montana, with consumer group sessions in Miles City, Billings, Polson, and Havre. Two additional focus groups were conducted with employers in Missoula representing professional services firms such as finance, real estate, health care, consulting, and engineering businesses, and a group of Miles City employers in the hospitality sector composed of motel, casino, gas station, restaurant, and convenience store firms.

The remainder of this report is specifically about the 2003 Montana Household Survey and the Montana Employer Survey. Written reports on key informant and the focus group component of the HRSA State Planning Grant research are available separately. Links to these other reports and other information for the program are available on the DPHHS State Planning Grant Program website: http://www.dphhs.mt.gov.

## Outline of This Report

This report is divided into several chapters, each focusing on examining variations in uninsurance rates and the characteristics of the uninsured in Montana from a different perspective. The report is organized as follows:

- Chapter 2 provides summary information at a statewide level on uninsurance rates and the characteristics of the uninsured;
- Chapter 3 describes the cost, sources of coverage, and individual insurance coverage findings from the household survey;
- Chapter 4 provides information at a statewide level on employers offering of health insurance by firm size, degree of employer coverage, factors affecting employer insurance plans, and business attitudes toward different policy options; and
- Chapter 5 concludes the report with a summary of survey results and their implications for Montana health policy.
- Finally, Appendix A and Appendix B include more detailed information on survey methodology and the development of statistical weights for analyzing the data, and 2002 federal poverty levels.

# Chapter 2 Household Survey: Findings State Overview

This chapter of the report presents the statewide findings of the 2003 Montana Household Survey and the Employer Survey. First, it examines the overall rate of uninsurance. Next, it presents information describing the characteristics of the uninsured in Montana, and provides an analysis of potential sources of health insurance coverage for the uninsured.

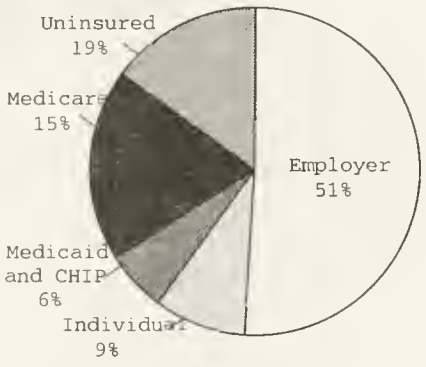
Major findings for Montana reported in this chapter include:

- High uninsured rates for all Montanans, especially young people between the ages of 19 and 25, for American Indians of all ages, and for persons with poverty level incomes;
- Employer based insurance rates below national rates;
- High proportion (72 percent) of Montana's uninsured was not insured for all of the past 12 months;
- Large numbers of Montana's uninsured are employed, in permanent jobs, in firms with 10 or fewer employees and in industries such as agriculture, construction, government, and hospitality and personal services;
- Large numbers of Montana's uninsured have higher incomes and post-high school education levels;
- High proportions of public program coverage from Medicare, Medicaid, and the Children's Health Insurance Program;
- The uninsured rate of 17 percent for Montana's youth is one of the highest uninsured children rates in the U.S.;
- Montana's working poor who are just above the Federal poverty level have uninsured rates of 48 percent.

## Montana's Uninsured Rates

Overall, 19 percent of Montanans, or approximately 173,000 people, were uninsured at the time of the 2003 survey. These results are illustrated in Figure 2-1.

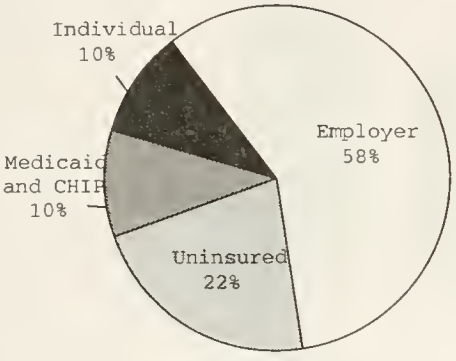
Figure 2-1 Insurance Coverage by Type, Montana, 2003 (n=2,941)




Slightly more than half (51%) of all Montanans had employer-based health insurance. Individual health insurance policies accounted for 9 percent of the state's population. Medicaid and the Children's Health Insurance Program (CHIP) accounted for 6 percent, a rate that was lowered somewhat by counting persons who were dual enrolled in Medicare and Medicaid as being Medicare insured. Medicare covered 15 percent of Montana's population. Uninsured rates for the non-elderly population are a more accurate measure of the health insurance gap in Montana since nearly everyone 65 years of age and older has health insurance through Medicare.

Montana's uninsured rate is higher when the elderly who are covered by Medicare are taken out of the sample and population numbers (Figure 2-2). Twenty-two percent of Montana's non-elderly population does not have any kind of health insurance-public or private. Employer-based insurance covers 58 percent of Montanans under 65 years of age compared to a national rate of 67 percent. Individual health insurance coverage is 9 percent in Montana compared to a national rate of 7 percent. Medicaid and CHIP account for 10 percent of the state's non-elderly health coverage.

Figure 2-2 Insurance Coverage by Type for Non-Elderly (Under 65 Years of Age)
Montana, 2003 (n=2,348)




Health insurance rates by age show considerable variation (Figure 2-3). The overall uninsured rate for all ages of 19 percent is significantly exceeded by the 39 percent rate for young people between 19 and 25 years of age. The next age group of 26 to 49 year olds has a rate of 24 percent while older Montanans between 50 and 64 years of age have an uninsured rate of 14 percent. Montana youth 18 years old and younger have an uninsured rate of 17 percent, one of the highest children uninsured rates in the nation.

Sources of insurance vary by age as shown in Figure 2-4. Fifty-seven (57.1) percent of children 18 years of age and under have insurance coverage through employers, primarily based on a parent's employment. About 16 percent of Montana kids 18 and under receive health insurance coverage from Medicaid or CHIP, one of the highest coverage rates of any age group.

Household income levels are a major determinant of health coverage. Lower income households, as shown in Figure 2-5, have higher rates of uninsurance. About 43 percent of persons in households with income below the 2002 federal poverty level of $18,100 for a family of four (see Appendix A, Table A-4 for federal poverty levels) do not have health insurance coverage. The uninsured rate drops for the next poverty bracket of 101 to 125 percent and then increases and remains high until household income levels are more than 200 percent of the federal poverty level. Persons living in households with more than two times the poverty level have a relatively low uninsured rate of 13 percent.

Figure 2-3 Montana Uninsured Rate by Age, 2003

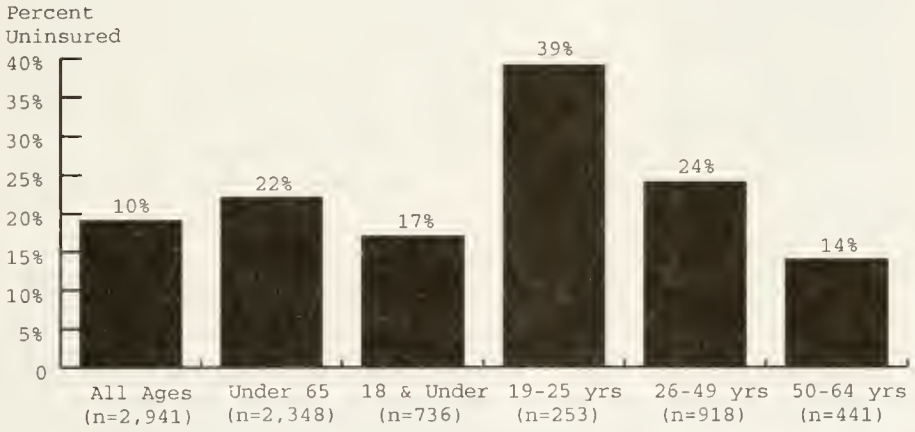



Figure 2-4 Insurance Coverage by Age and Type for Montana Residents Under 65 Years of Age, 2003

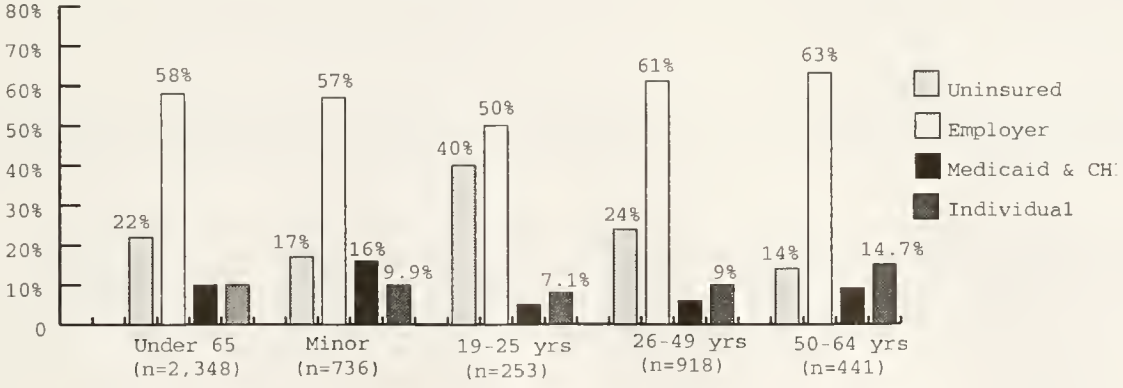
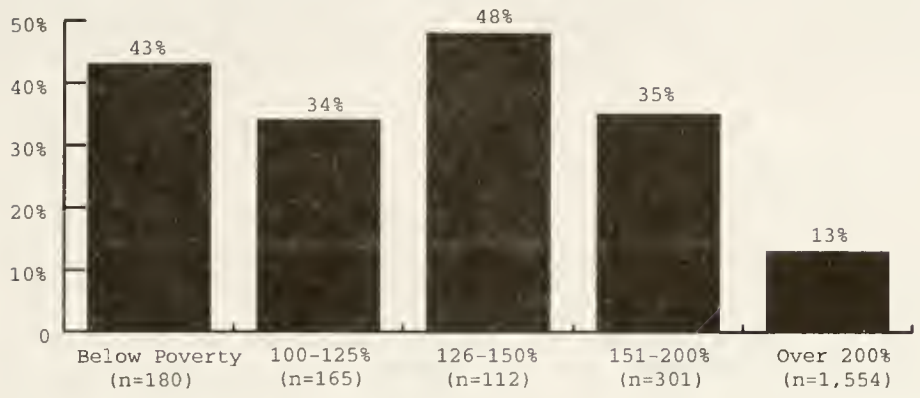
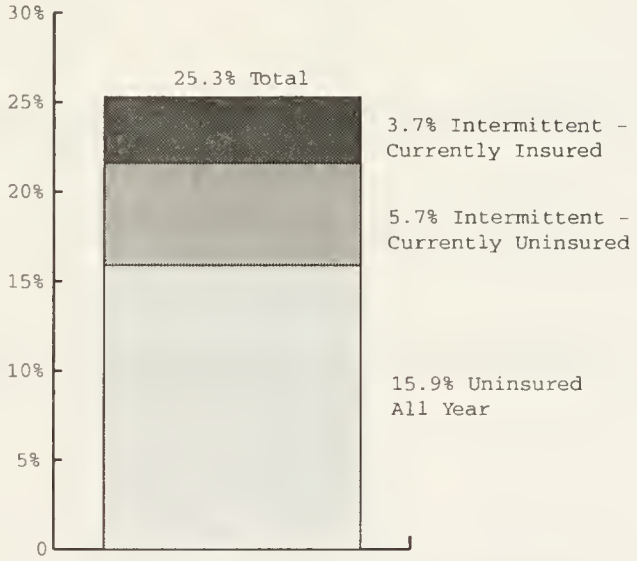


Figure 2-5 Uninsured Rate by Income as a Percent of Poverty, Montana Residents 0-64 Years Old, 2003




Rates of uninsured in this report are point-in-time estimates from telephone calls during the first five months of 2003. Persons reported their insurance status at the time of the phone call, as well as insurance status over the past year. It is possible to estimate transitions between insured and uninsured from this information since it is possible to identify respondents who did not have insurance during the past 12 months, those who were uninsured at the time of the interview but were covered at some point during the past 12 months, and those who were covered but did not have insurance at some point during the past 12 months.

Fig 2-6 Montana Uninsurance Rates in 2003 Using Alternative Definitions (n=2,941)




These different measures for Montana's non-elderly population are shown in Figure 2-6. Almost 16 percent of the 22 percent uninsured rate for non-elderly Montanans represent the long-term uninsured that were not insured all year. Another 5.7 percent were intermittently insured during the past 12 months but not at the time of the interview. Intermittent with current coverage is a third group representing 3.7 percent of the Montana's non-elderly population. The uninsured rate for the long term and the two intermittent categories represent a rate of persons 25.3 percent of non-elderly Montanans who were uninsured at some point in the past year. One in four of every non-elderly Montanan in the state lacked health insurance at some time during the year.

A summary of Montana uninsurance rates along with 95 percent confidence intervals by population group is shown in Table 2-1. Several important rates not previously discussed show racial, geographic, and employment variations in health care coverage.

American Indians under sixty-five years of age had a 38 percent uninsured rate compared to a rate for a combined racial group of non-elderly whites and other races of 20 percent. Following Census Bureau methods, the Indian Health Service was not considered a source of health insurance since it is not available to all Indians or in all areas, and its availability and level of service is contingent on federal government budget decisions.

Montana's uninsured rates of 21 percent in urban areas were slightly lower than the 23 percent rate in rural areas.

Uninsured rates varied over different employment status categories. The uninsured rate for the self-employed was 24 percent compared to a 19 percent rate for employed persons. Unemployed persons had an uninsured rate of 41 percent. full time students had a 27 percent uninsured rate. Disabled and retired persons had uninsured rates of 12 percent.

**Table 2-1**
**Summary of Montana Uninsurance Rates**
**by Population Group, 2003**

| | Uninsurance Rate | 95% Confidence Interval |
|---|---|---|
| Total population (n=2,941)19% | 17 to 20% | |
| Age | | |
| 0-18 | 17% | 14 to 19% |
| 19-25 | 39% | 34 to 45% |
| 26-49 | 24% | 21 to 27% |
| 50-64 | 13% | 10 to 16% |
| 65+ | 0.5% | 0.1 to 0.9% |
| Population under age 65 (n=2,348) | 22% | 20 to 23% |
| Race | | |
| White & other | 20% | 18 to 22% |
| American Indian | 38% | 31 to 45% |
| Residency | | |
| Urban | 21% | 18 to 23% |
| Rural | 23% | 20 to 26% |
| Household income as a percent of Federal poverty guidelines | | |
| <100% | 43% | 35 to 50% |
| 101-125% | 34% | 26 to 41% |
| 126-150% | 48% | 38 to 57% |
| 151-200% | 35% | 29 to 40% |
| Over 200% | 13% | 12 to 15% |
| Employment Status | | |
| Self-employed | 24% | 20 to 28% |
| Employed | 19% | 17 to 21% |
| Unemployed | 41% | 33 to 49% |
| Disabled | 12% | 4 to 19% |
| Full-time student | 27% | 18 to35% |
| Retired | 12% | 4 to 19% |

Rates are based on a weighted sample for the state of Montana.
*Upper and lower bounds are for 95% confidence interval.

## Socio-Economic Characteristics of Montana's Uninsured

Table 2-2 provides information on the demographic characteristics of Montana's uninsured population in 2003. The uninsured are most likely to:

- Be white (86 percent of the uninsured);
- Be adults over 25 years of age (67 percent between the ages of 26 and 64);
- Have a high school education or higher (92 percent);
- Be single or divorced/separated (31 percent + 15 percent for combined 46 percent);
- Have household incomes more than twice (over 200 percent) of the federal poverty level (45 percent of the uninsured).
- Be self-employed or employed by someone else (77 percent in Table 2-3).

High proportions of Montana's uninsured are educated and older and have income levels above the federal poverty level.

**Table 2-2**
**Demographic Characteristics of Montana's Uninsured Population Under 65 Years of Age, 2003**

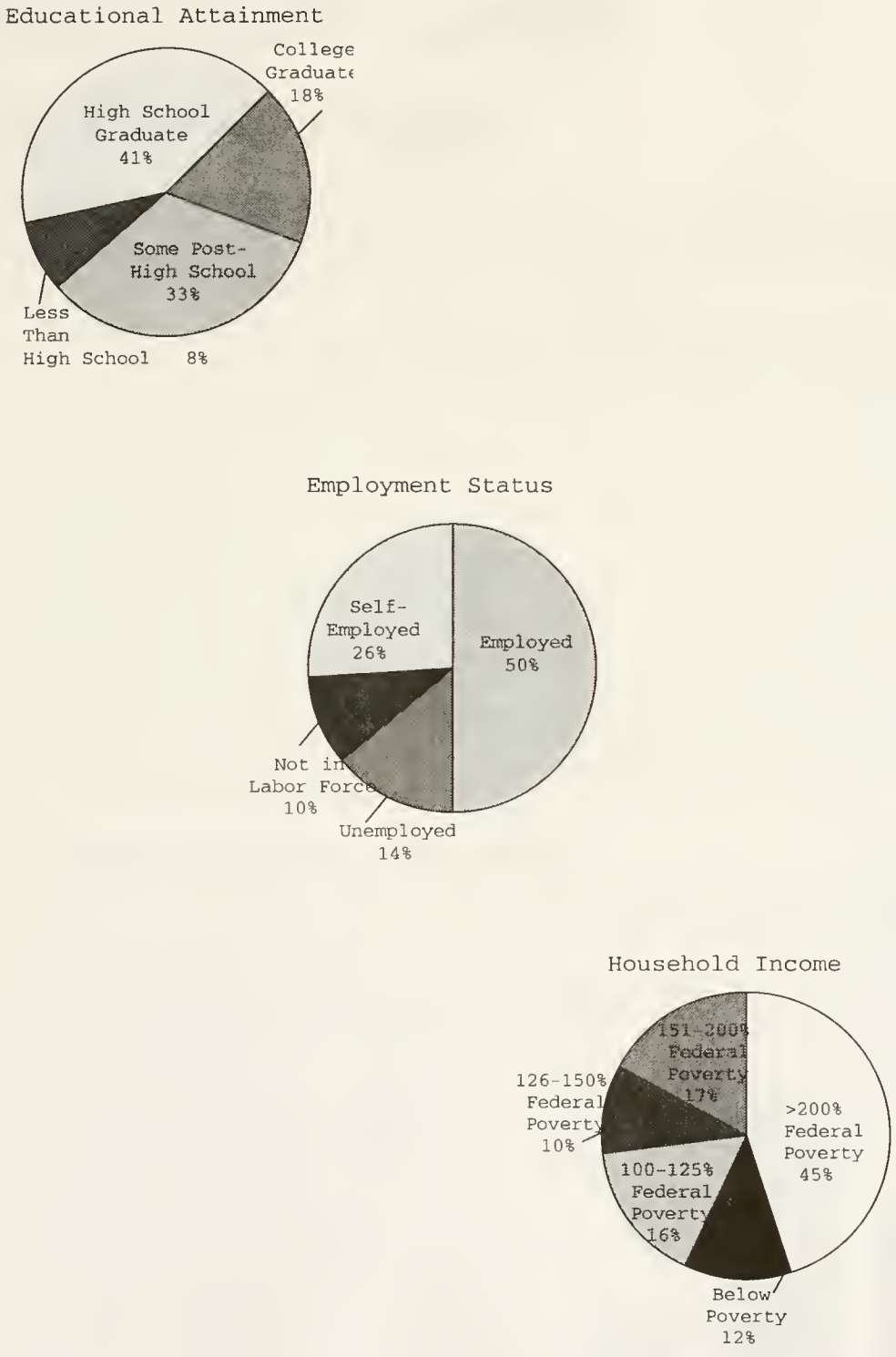
| | Proportion of Uninsured (n=1,227) |
|---|---|
| Gender (n=1,227) | |
| Male | 50% |
| Female | 50% |
| Residency (n=1,227) | |
| Urban | 43% |
| Rural | 57% |
| Age (n=1,227) | |
| 18 & under | 18% |
| 19-25 | 15% |
| 26-49 | 42% |
| 50-64 | 25% |
| Household Income as % of Federal Poverty Guidelines (n=1,168) | |
| <100% | 12% |
| 101-125% | 16% |
| 126-150% | 10% |
| 151-200% | 17% |
| Over 200% | 45% |
| Household Composition (n=1,153) | |
| Single | 31% |
| Married | 45% |
| Living with a partner | 9% |
| Divorced/Separated/Widowed | 15% |
| Education of Target or Responsible Adult (n=1,157) | |
| Less than high school | 8% |
| High school graduate or GED | 41% |
| Some post high school | 33% |
| College graduate | 15% |
| Post graduate | 3% |
| Race (n=1,227) | |
| White & other | 86% |
| American Indian | 14% |

A large majority of uninsured Montanans is employed (Table 2-3 and Figure 2-7). Twenty-six percent of the uninsured were self-employed and 51 percent by someone else (for uninsured children, these statistics refer to the primary wage earner in the family). A high percent of employed Montanans without insurance were in permanent jobs (84 percent) and were employed by small employers of 10 or fewer employees (56 percent). Industries with high proportions of the uninsured included agriculture, construction, government, hospitality services such as motels, casinos, convenience stores, and gas stations, other services such as personal and repair businesses, and retail trade.

**Table 2-3**
**Employment Status of Montana's Uninsured Population Under 65 Years, 2003**

| | Proportion of Uninsured |
|---|---|
| **Employment status of target or responsible adult (n=1,167)** | |
| Self-employed | 26% |
| Employed by someone else | 51% |
| Unemployed | 14% |
| Disabled | 2% |
| Full-time student | 5% |
| Retired | 2% |
| **Type of employment (n=863)** | |
| Permanent | 84% |
| Temporary | 7% |
| Seasonal | 9% |
| **Size of employer (n=839)** | |
| 1 employee | 20% |
| 2 to 10 employees | 36% |
| 11 to 19 employees | 9% |
| 20 to 50 employees | 12% |
| 51 to 100 employees | 6% |
| 101 to 500 employees | 5% |
| More than 500 employees | 12% |
| **Industry of employer (n=853)** | |
| Agriculture | 9% |
| Manufacturing | 4% |
| Mining/extraction | 2% |
| Transportation/utilities | 3% |
| Construction | 15% |
| Government | 11% |
| Professional services | 6% |
| Hospitality services | 16% |
| Other services | 22% |
| Trade | 12% |

## Figure 2-7 Who are Montana's Uninsured?



# Chapter 3: Household Costs and Coverage

The high costs of health insurance and healthcare are pervasive themes in many of the responses from the household and employer surveys, key informant interviews, and focus groups. Medical debt is one direct impact of high health insurance and health care costs. The Household Survey questioned respondents on their unpaid medical bills during the past 12 months. Responses to these questions are shown in the following figures.

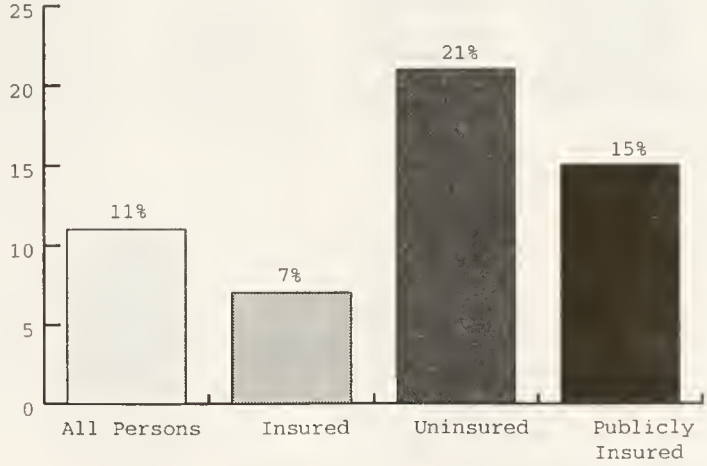
In addition to collecting information on basic health insurance coverage, the 2003 Montana Household Survey and the Montana Employer Survey asked specific questions about other issues of interest to policy makers, such as medical debt, insurance affordability, and individual insurance policies. Major findings for Montana reported in this chapter include:

- Uninsured persons were more than 3 times as likely to have medical debt (21 percent) compared to those with health insurance (7 percent);
- Average medical debt was $2,500 or higher and represented as much as 16 percent of household income for persons without health insurance;
- Being uninsured is not voluntary with 90 percent of the uninsured reporting being unable to buy health insurance after paying for food, clothing, and shelter;
- Uninsured can afford to pay low monthly premiums, averaging about $96 per month;
- Montana's uninsured did have coverage in the past, with only 20 percent reporting no previous health insurance;
- High average deductibles of more than $3,000 for persons with individual insurance policies;
- Individual insurance policies take a big bite of monthly household income ranging from 21 percent for people below twice the poverty level and 8 percent for persons more than 2 times (200 percent) above the povertylevel;
- Households of one person and those with 5 or more people have higher uninsured rates compared to unin sured rates for households with 2 to 4 persons.

## Costs and Affordability for Households

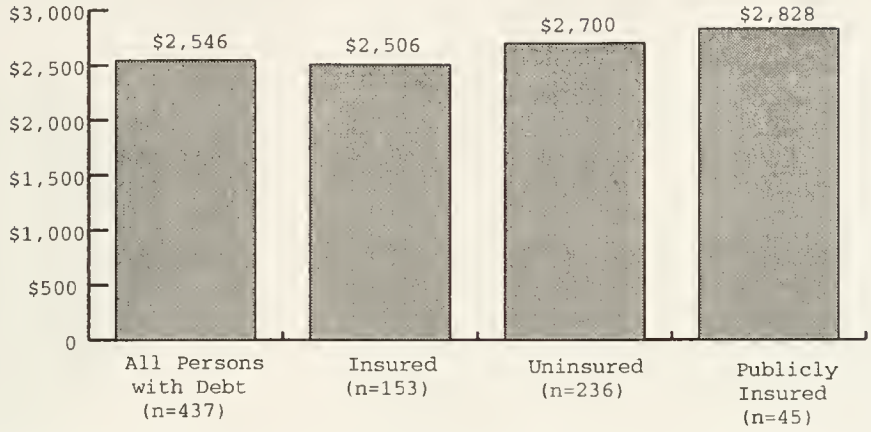
Eleven percent of all non-elderly Montanans had medical debt in the past 12 months. There were differences by insurance status with 7 percent of insured Montanans having medical debt and more than 3 times that percent or 21 percent of uninsured persons with medical debt. Public health insurance coverage did not eliminate the impact of medical debt on low-income households. Fifteen percent of the publicly insured did have medical debt.

Figure 3-1 Montana Residents 0-64 Years Old With Medical Debt, 2003 (n=2,251)




Average dollar amounts of medical debt are shown in Figure 3-2. Average debt was high for every insurance coverage category. Montanans with medical debt had, on average, $2,546 in unpaid medical bills over the past 12 months. Average debt was slightly smaller for persons with health insurance ($2,506) and increased to a level of $2,700 for persons without health insurance. Publicly insured individuals had the highest average medical debt with a value of $2,828.

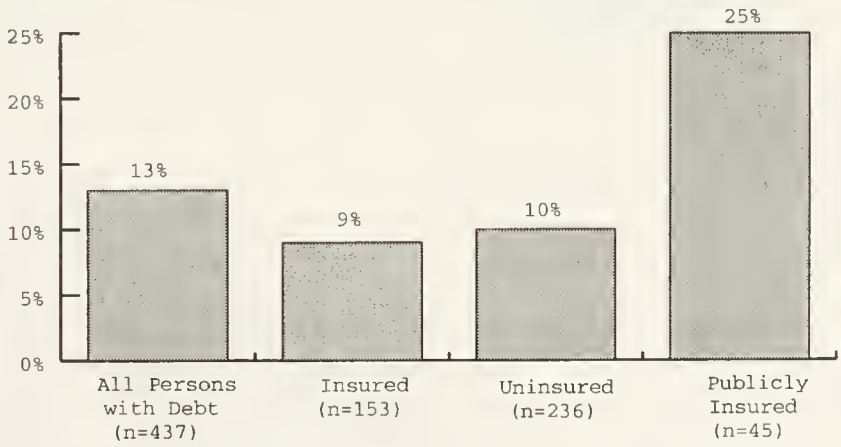
Figure 3-2 Average Medical Debt for Non-Elderly Montanans, 2003




Medical debt due to family out-of-pocket health bills is another important measure of healthcare cost impacts on Montana families. Figure 3-3 shows a significant range of medical debt impacts on household and individual budgets in the state during 2003. Statewide medical debt was 13 percent of household income. The debt-household income ratio dropped to 9 percent for persons with health insurance. The uninsured had medical debt equal to 16 percent of the income of the household in which they resided. Publicly insured individuals had medical debt representing 25 percent of their household income.

Health insurance premium costs can dramatically impact household budgets taking away income/money for other, non-health purchases. How much choice uninsured persons have to buy or not buy health insurance coverage is an important behavioral aspect of the uninsured. The issue of choice is based on whether uninsured persons choose not to spend their income on health insurance or are forced not to buy insurance due to a lack of household income after paying for housing, groceries, and other basic necessities. Some advocates of the choice explanation argue that people would rather spend their money on snowmobiles and other consumer luxuries that preclude buying health insurance.

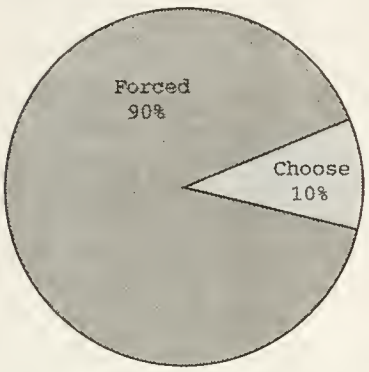
Figure 3-3 Medical Debt as a Percent of Montana Household Income, 2003




The 'snowmobile' hypothesis of discretionary choice and household spending was examined by asking respondents in the Household Survey which statement best applied to them: a) if they choose not to because they are healthy and would like to spend their money on other things that are not absolutely needed to live or b) if they must use all of the money they have for absolutely necessary things like food, clothing, and housing instead of health insurance.

Ninety percent of the uninsured said lack of insurance was forced or due to lack of budget for health insurance after paying for the basic life necessities such as food, clothing, and housing. This response pattern was reinforced by the comments and discussion of focus group participants who cited high monthly premiums as beyond their monthly income (see Focus Group Report).

Figure 3.4 Are Montana's Uninsured Forced Because of Cost or Do They Choose to be Uninsured? 2003 (n=1,1227)




Health insurance cost-impacts on household budgets were explored through several other questions in the Household Survey. Montanans were asked if they could afford a monthly premium and how much could they afford to pay for that monthly premium. As Figure 3.5 shows, 81 percent of the respondents indicated that they could afford a monthly premium. Ninety-six dollars ($96) was the amount indicated as affordable.

Insurance and health care cost impacts on households are especially burdensome in a low-income state like Montana. The predominance of low income working households makes the availability of public health programs especially important. Qualitative data from focus discussion groups representing individual perceptions supplements some of the quantitative information on Medicaid and CHIP enrollment presented earlier.

Focus group comments on Medicaid included a person with two kids, no insurance, and earning too much money to qualify for Medicaid. Several focus group members experienced applying to the CHIP program but being just above the income eligibility cutoff. Another person worked for a doctor that limited the number of Medicaid patients. One focus group participant thought that CHIP was a great program but was dismayed at yearly cuts in the program. Another consumer had problems with CHIP because certain doctors would not accept it.

The Montana Comprehensive Health Association (MCHA) and COBRA (extension of health insurance benefits after losing a job) are two policy options designed to alleviate a lack of health insurance. Comments on MCHA indicated that it was expensive. The cost of health insurance under COBRA was too high for some people. Some focus group members felt that once a person lost his or her job there should be some way that person could afford to keep their insurance (Focus Group and Key Informant results are available at http://www.dphhs.mt.gov).

Figure 3-5 Can Montanans Afford a Monthly Premium? (n=1,227)

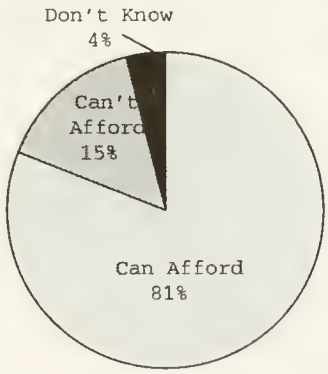
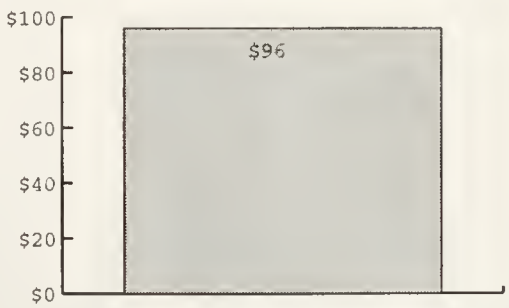



Figure 3-6 How Much Can Montanans Afford to Pay Per Month? (n=1,227)



## Sources of Coverage

Health insurance status and sources of health insurance for those who were insured varied over age, race, household income, and other factors. As discussed earlier, American Indians had a 38 percent uninsured rate (Table 2-1) compared to a 20 percent rate for whites and others. American Indians had lower rates of employer-based health insurance (36 percent) compared to whites (Figure 3-7) and other races (61 percent), a 23.4 percent rate of Medicaid and CHIP coverage compared to 8.4 percent for whites and other races, and a very small rate of individual insurance.

Employer based insurance coverage varied by household size (Figure 3-8) and by average income (Figure 3-9). Persons in households of two, three, and four persons were more likely to be covered on the jobs with coverage rates varying from 61.1 percent to 59.7 percent to 64.1 percent. Uninsured rates were 29.5 percent for one-person households and 24.4 percent for households of five or more persons. Medicaid and CHIP coverage rates did not vary significantly by household size. Average household income was higher for persons covered by individual insurance and by employment based insurance.

Figure 3-7 Insurance Coverage of Montana Residents by Race, Under 65 Years of Age, 2003 (n=2,348)

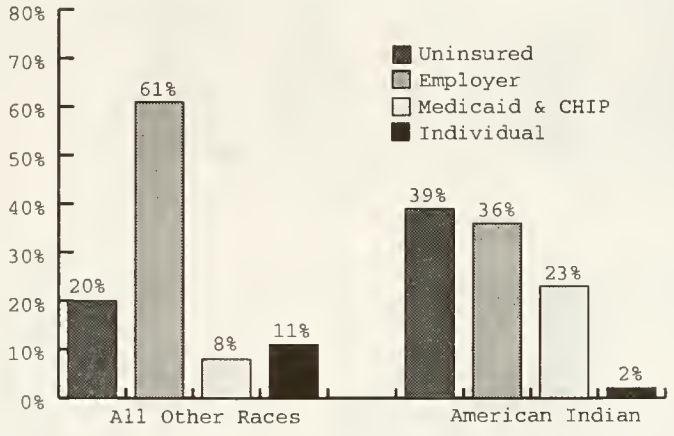
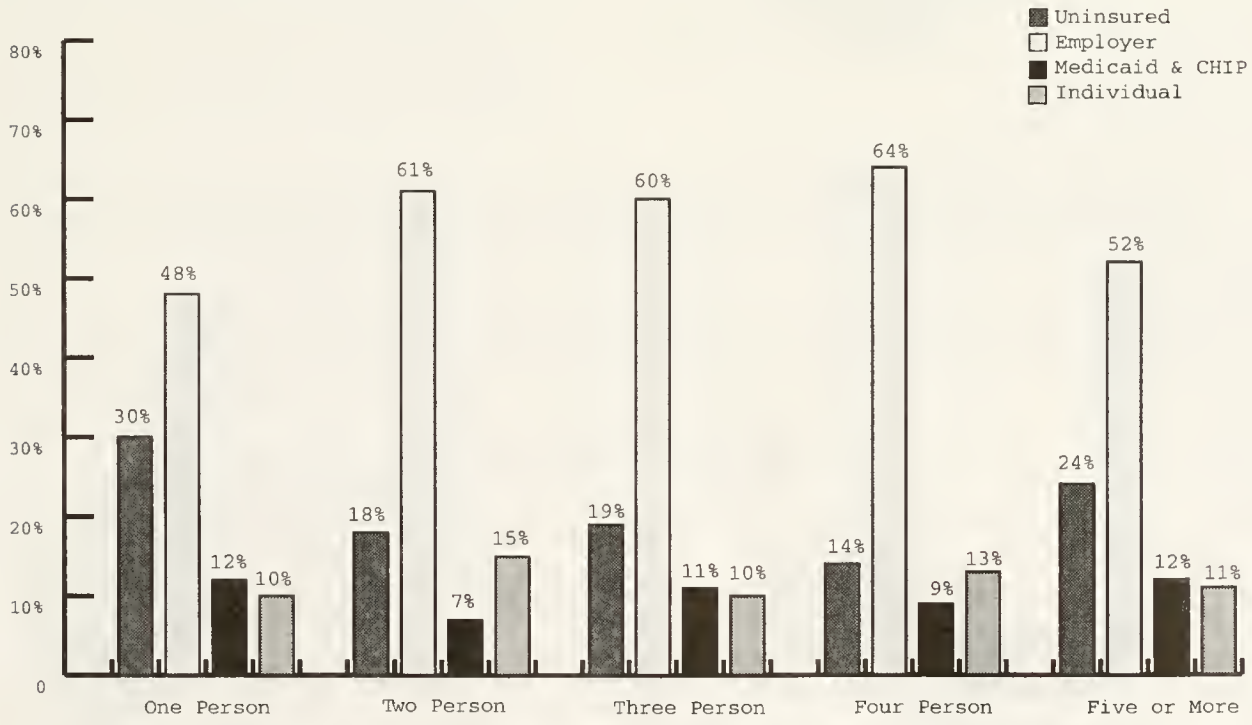



Figure 3-8 Insurance Coverage by Household Size, Under 65 Years of Age, 2003 Montana Residents (n=2,348)



Most uninsured Montanans had previous insurance coverage (Figure 3-10). More than half, 56 percent, had previously been covered by employers, 12 percent had individual coverage in the past, and another 9 percent had been insured by a public program. Only 20 percent of the uninsured had never had previous health insurance. Focus group comments corroborated some of these patterns– participants indicated they used to have health insurance on the job but it was dropped when coverage became too expensive to their employer. Other participants indicated availability of health insurance on the job when business conditions were better with a subsequent dropping of coverage by their employer when business conditions were bad (see Focus Group Report).

Figure 3-9 Insurance Coverage of Montana Residents by Race, Under 65 Years of Age, 2003 (n=2,348)

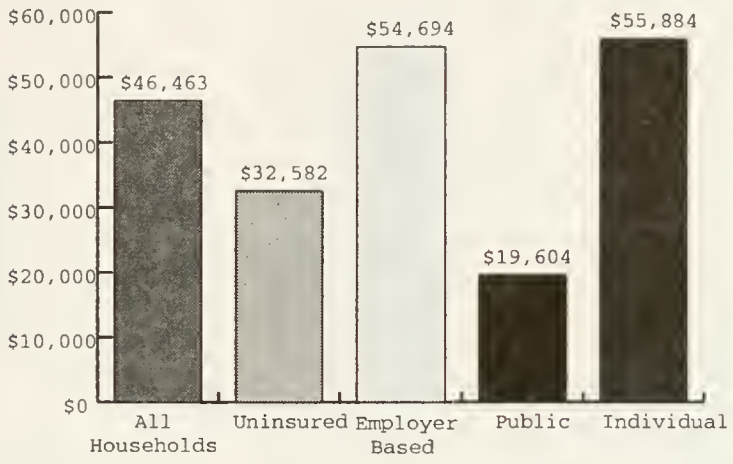
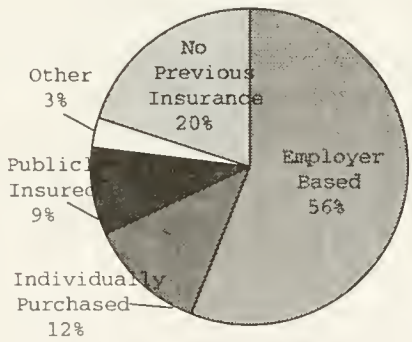



Figure 3-10 Previous Insurance Coverage of Montana's Uninsured (n=1,227)




## Individual Health Insurance Coverage

Individual health insurance policies covered 10 percent of non-elderly Montanans in 2003. Figure 3-11 shows the breakdown of this 10 percent. Fifty- seven percent of persons reporting individual policies had them on a family basis. Eighteen percent were policies for the individual only and another 25 percent had individual policies provided by someone outside the immediate household.

Nearly all of the individual insurance policies required a deductible amount (Figure 3-12). Slightly more than 40 percent of individual insurance covered persons had prescription drug benefits. About 10 percent had a dental benefit and 10 percent reported having a partner who got their insurance through work.

Figure 3-11 Individual Insurance Type of Policy for Non-elderly Montanans, 2003 (n=714)

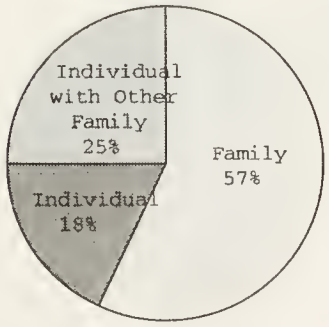



Figure 3-12 Individual Insurance Policy Options f Montana's Non-elderly Residents, 2003 (n=714)

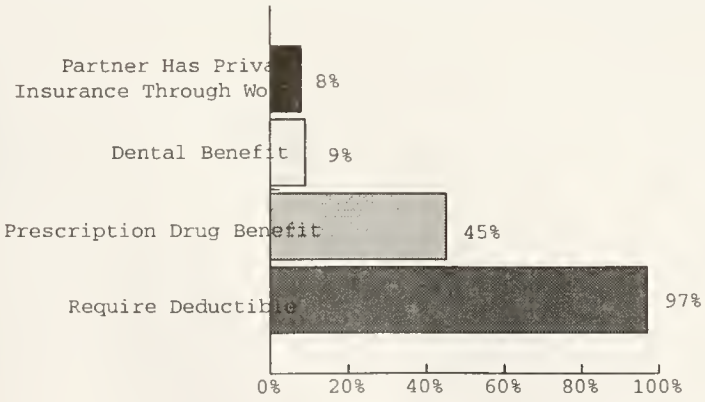


Figure 3-13 Average Individual Insurance Monthly Premiums for Non-elderly Montana Residents, 2003

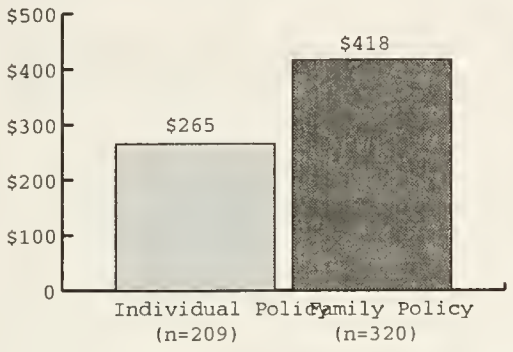



Figure 3-14 Average Individual Insurance Yearly Deductibles for Non-elderly Montana Residents, 2003

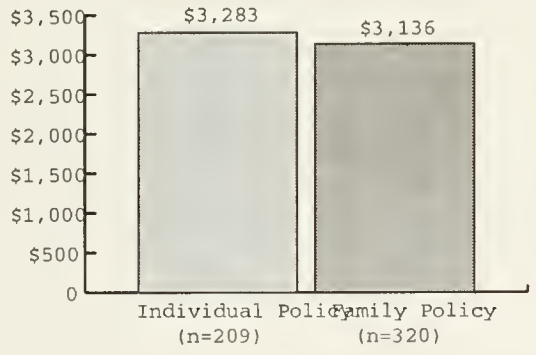
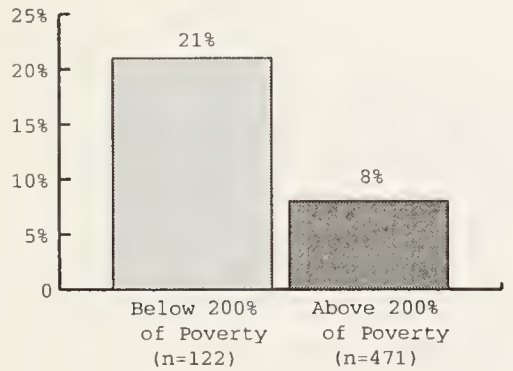



Figure 3-15 Individual Insurance Premiums as a Percent of Monthly Household Income for Montana Residents (less than 65 years old) 2003




Individual health insurance premiums vary between individual and family policies for individual insurance. Figure 3-13 shows an average monthly premium of $265 for a single individual policy in the individual insurance market. The average for family coverage in the individual insurance market is $418. Figure 3-14 shows average deductibles of $3,283 for a single individual policy and a deductible of $3,136 for a family policy.

The relationship between individual insurance premium costs and income is shown in Figure 3-15 for household income 200 percent or below of the federal poverty level and for household income above 200 percent of poverty ($36,200 for a family of four in 2002). Individual insurance premiums for lower income households (below 200 percent of poverty) represent, on average, 21 percent of their household income. The budget impact of insurance premiums is considerably lower for higher income households, representing about 8 percent of monthly household income.

Focus group comments (see Focus Group Report) substantiated the high costs of individual insurance premiums. Self-employed persons such as ranchers and small business owners cited high premium costs as a real burden for their individual insurance coverage.

# Chapter 4: Employer Survey

The 2003 Montana Business Insurance Survey was a stratified random telephone survey of businesses located in Montana covered by unemployment insurance. The data were collected by the Survey Research Center at The University of Montana-Missoula, Bureau of Business and Economic research from March 2003 to May 2003.

A key objective of the survey was to fill in gaps in our knowledge about Montana business offering of health insurance to their employees. The survey sampling methodology was designed to obtain a higher number of completed interviews from larger businesses because most Montana businesses have fewer than 10 employees. In order to achieve these goals, the survey was conducted as a stratified random sample, where the strata were business size.

Major findings for Montana reported in this chapter include:

- Forty percent of small firms with 10 or fewer employees offer health insurance;
- One third of small firms offering health insurance offer it to all employees;
- More than 90 percent of large firms with 100 employees offer health insurance;
- Only half of large firms offering health insurance offer it to all employees;
- Eighty one percent of Montana firms not offering health insurance cite high premiums as the major reason why they do not offer insurance;
- More than 80 percent of employers cite higher prices for hospital care, prescription drugs, physician care, and malpractice insurance as major reasons for health insurance premium increases;
- When asked why their eligible employees did not use the health insurance coverage offered, 28 percent of the employers responding to this question cited high premium costs and the affordability of insurance as the major reason;
- 67 percent of firms not offering insurance thought they would provide insurance under a tax credit policy;
- More than 40 percent of firms not offering insurance indicated they would 'absolutely' participate in a small business purchasing pool;
- Average monthly premium for 'employee only' was $35 for the employee and $260 for the employer; and,
- Average monthly premium for 'employee and family' was $122 for the employee and $475 for the employer.

## Major Findings

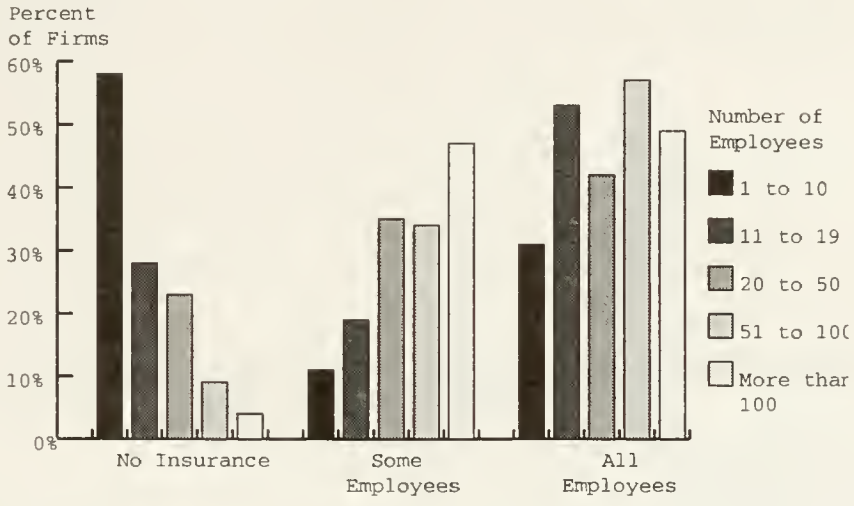
Firm size by the number of employees was the major determinant for offering of job-based health insurance in Montana. Fifty-nine percent of Montana firms with 10 or fewer employees did not offer health insurance (Figure 4-1 and Table 4-1). There was some difference in insurance offer rates when the small firm cutoff of 10 or fewer employees was subdivided into firms with 1 to 5 employees, 63 percent of whom did not offer insurance, and firms with 6 to 10 employees where 48 percent of the firms in this size group did not offer insurance.

The percent of firms not offering insurance decreased to 29 percent for firms with 11 to 19 employees and continued to drop as firm size increased. More than 95 percent of firms with more than 100 employees offered health insurance, and 100 percent of very large employers of 500 or more workers offered health insurance.

Not all workers in a firm were offered insurance, no matter how large the firm. Small firms offered coverage to a portion of their employees. Large firms offered insurance to a higher proportion of their work force, although not necessarily to their entire work force. The average number of hours worked per week as a requirement for health coverage was 30 hours. The average number of months waiting period before becoming eligible for the employer's health coverage plan was four months.

Thirty percent of firms with 10 or fewer employees offered insurance to all employees, a rate that increased to 53 percent for firms of 11 to 20 employees. The proportion of firms offering insurance to all employees remained at about 50 percent for firms up through those with more than 100 employees. Large firms with 200 or 500 or more employees had a high offer rate approaching 100 percent, but the insurance was not offered to all employees.

Figure 4.1 Montana Employers Offering Insurance by Number of Employees, 2003 (n=520)

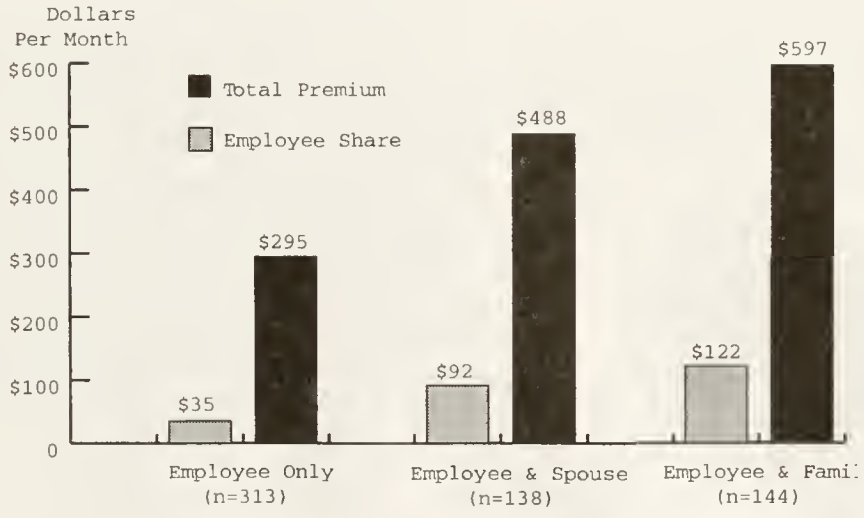



Monthly health insurance premiums for employer-based health insurance are made up of the employer's share and the employee's share. These shares in dollar amounts for Montana workers and employers were measured (Figure 4-2) by insurance premiums for the employee only, for employee and spouse, and for employee and family. Average monthly premiums for employee only coverage were $35 dollars for the employee with the balance of $295 representing the average share over employers. Total monthly premiums of $488 for employee and spouse coverage included an average $92 premium for the worker. Family coverage was $597 of which about 21 percent or $122 was paid by the employee.

**Table 4-1: Montana Firms Offering Health Insurance, 2003, (n=520)**

| | Percent offering Health Insurance | | |
|---|---|---|---|
| # of Employees | No Insurance | Certain Employees | All Employees |
| 1 to 5 | 63% | 9.4% | 27.5% |
| 6 to 10 | 47.7% | 15.4% | 36.9% |
| 11 to 20 | 28.1% | 18.8% | 53.1% |
| 20 to 100 | 20.1% | 34.4% | 45.5% |
| More than 100 | 3.9% | 47.4% | 48.7% |

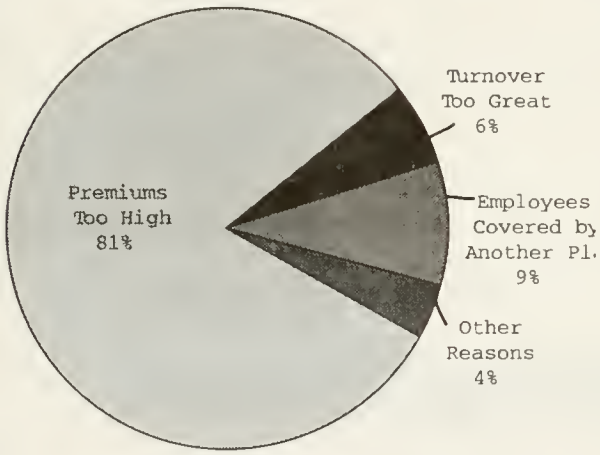
Figure 4-2 Average Monthly Health Insurance Premiums Montana Employers, 2003 (n=218)



Employer costs of health insurance premiums were cited as the major reason that employers identified as to why they either did not offer or thought firms did not offer health insurance (Figure 4-3). Eighty one percent of the firms responding to this question thought premiums were too high and prevented firms from offering insurance (see Key Informant Interview results on website). Six percent thought high turnover was a major determinant of Montana firms not offering health insurance coverage and another 9 percent thought that employees were covered by another plan, perhaps that of their spouse or partner, and therefore did not need to be offered insurance.

Montana employers were asked reasons why their eligible employees did not use the health insurance coverage offered (figure 4-4). Sixty five percent of the employers thought or knew that their employees were covered by another plan. Five percent of the employers said that their employees not using the firm's coverage were employees who thought they did not need insurance. Twenty-eight percent of the employers responding to this question cited high premium costs and the affordability of insurance as the major reason some of their workers did not use the firm's health insurance plan.

Figure 4-3 Why Montana Firms Do Not Offer Health Insurance Coverage, 2003 (n=302)




## Employer Views on Costs and Policy Options

Employers' concerns over health insurance premium costs and increased premiums were examined through the views on health insurance premium increases in 2003 (Figure 4-5). Higher prices for basic medical services such as hospital care, prescription drugs, and physician care were the most frequently cited factors for higher premiums in the view of Montana employers. Malpractice insurance costs were another factor thought to be driving higher insurance premiums. Better medical technology, higher insurance company profits and higher health care utilization by consumers were three factors also cited, although with a lower frequency by employers.

Policy options for increasing employer based insurance coverage were examined in the employer survey. Montana employers not offering health insurance (n=302) were asked about their reaction to tax credits that would offset a portion of the health insurance premiums for their workers. They were also questioned about attitudes and reaction to buy-ins into large, public health insurance plans, like the state employees' plan with eligibility confined to low-income employees. Employers were also asked about purchasing pool policies that would allow small businesses to join together to purchase insurance at rates similar to those found in large group plans. More detailed analysis of policy options will be conducted by the State Health Access Data Assistance Center located in the University of Minnesota School of Public Health (www.shdac.org).

Employer reactions to tax credits for health insurance premiums were qualified by credits with a sunset provision whereby the tax credits would be in effect for five years versus an unlimited time for the credit (no sunset). They were offered several choices for responses as shown in Figure 4-6A. Fifteen percent of the firms not currently offering insurance said they would not offer health insurance even if the tax credit policy option were offered. Eighteen percent said they did not know what their reaction would be to a tax credit. Nineteen percent said they would offer health insurance if the tax credit were 40 percent and another 48 percent said they would at a tax credit rate of 50 percent or higher.

Figure 4-4 Montana's Employers' Views of Why Eligible Employees Do Not Use Firm's Health Insurance Coverage, 2003 (n=347)

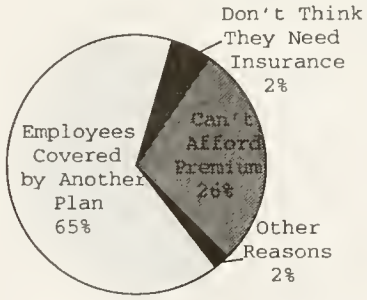


Figure 4-5 Montana Employer Views on Health Insurance Premium Increases in 2003 (n=520)

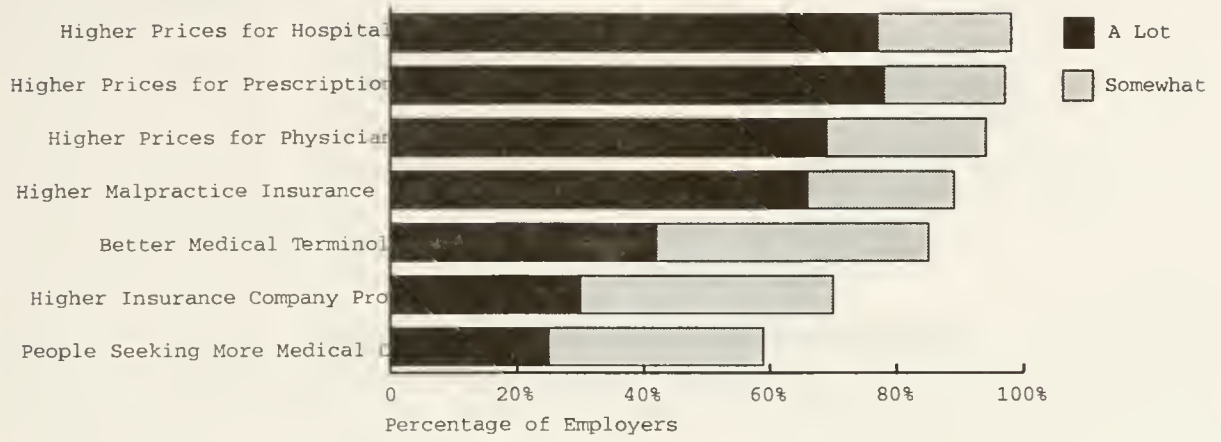



Figure 4-6A Tax Credit Rates Needed by Employers Who Would Offer Health Insurance 2003 (n=202)

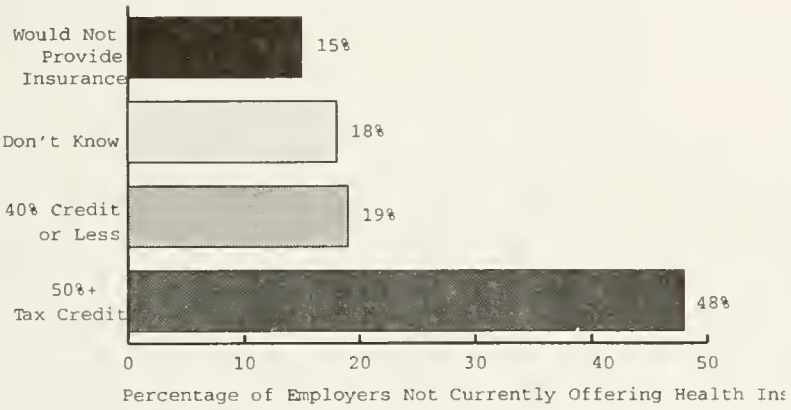
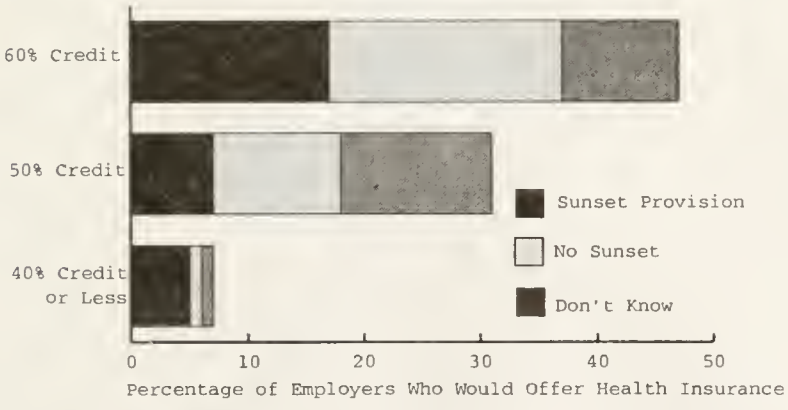



Figure 4-6B Tax Credit Rates Needed by Employers Who Would Offer Health Insurance 2003 (n=202)

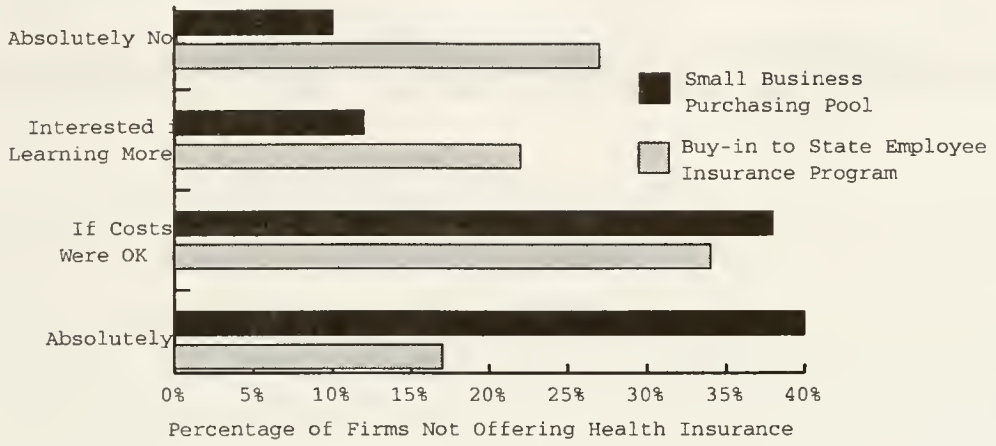



Employer reactions to tax credits with choices between the forty to sixty percent are shown in Figure 4-6B. The breakdown of the 67 percent of employers who would offer health insurance (Figure 4-6A) is shown in Figure 4-6B. Twenty-nine percent of the employers who would offer health insurance would need a 40 percent tax credit, another 40 percent of the employers would need a 50 percent credit and 31 percent of them would need a 60 percent credit although there were still some undecided with the choice of a sunset or no sunset provision included.

Two purchasing pool policy options of small business purchasing pools and buy-in to state employee insurance program were offered to employers during the survey interview session. Reaction to these two policy options was varied (Figure 4-7). A small percentage of firms not offering health insurance would still not offer insurance under either one of the two purchasing alternatives.

Other responses were conditional on learning more about the alternatives and on the cost arrangements of the alternatives. The strongest, unequivocal response of 'absolute' participation was on the small business purchasing pool where 40 percent of the firms not offering insurance said they would participate. A smaller 19 percent expressed willingness to participate with a buy-in to a state employee insurance program.

Figure 4-7 Montana Employer Views on Participating in Insurance Purchasing Alternatives, 2003 (n=170)



# Chapter 5: Summary Observations

There are population groups within the state that experience significantly higher rates of uninsurance than the statewide average.As shown in the preceding chapters, groups that are most likely to be uninsured include young adults, populations of American Indians, and people with lower incomes.

There are many different reasons why a person may lack health insurance. Qualitative research conducted through focus groups and key informant interviews as a complement to the 2003 Montana Household Survey and the Employer Survey identify that some of the main reasons for disparities in health insurance coverage are cost and affordability to consumers and to employers. Many small employers were barely able to afford insurance for themselves and their families. Differential access to employer-based and private health coverage was also a major factor in explaining why some persons had health insurance. Many jobs, especially in small businesses, were with employers that either did not offer health insurance to any workers or to only a select group of their workforce. Therefore, it is likely that no single strategy will succeed in reducing uninsurance rates for all of the population groups that experience higher rates of uninsurance than the statewide average. Instead, strategies will need to be tailored to particular groups of people, taking into consideration the wide variety of reasons for being uninsured.

Strategies for reducing the rate of uninsurance should be evaluated in terms of their potential to reach a large number of uninsured, as well as their potential to reduce disparities in uninsurance rates experienced by different population groups. In addition to the challenges of improving overall rates of insurance coverage and reducing disparities in uninsurance rates, Montana also faces the challenge of increasing insurance coverage in the face of rapidly rising health care costs. Private health insurance premiums having been growing at or near double digit rates in Montana similar to national data showing the same trend.

It is difficult to tell yet how these rapid increases in the price of insurance will affect rates of private health insurance coverage. Anecdotal evidence suggests that while businesses were experiencing strong economic growth and low unemployment, they were reluctant to increase the offering of health insurance to their workers. With a slowdown in the Montana economy and increased unemployment there may be more resistance to employer offering health insurance. If employers discontinue offering health insurance benefits or pass-on a higher share of the premium cost to employees, it is possible that more Montanans (particularly those with low incomes) could lose private health insurance coverage. Further research and monitoring will be needed to determine the impacts of rising health care costs and an economic slowdown on health insurance coverage in Montana.

# Appendix A- Household Survey Methodology

The 2003 Montana Household Survey was a stratified random digit dial telephone survey. The data were collected by the Survey Research Center at The University of Montana-Missoula, Bureau of Business and Economic research from December 2002 to May 2003.

A key objective of the survey was to fill in gaps in our knowledge about Montana's uninsured population. The survey sampling methodology was also designed to obtain a higher number of completed interviews among populations of American Indians. In order to achieve these goals, the survey was conducted as a stratified random sample, where the strata were geographic areas. As a way of obtaining sufficient sample sizes in the survey for populations of American Indians, Montana's rural areas were Figure A-1 shows the geographic regions for the sample. Table A-1 shows the sampling distribution of the strata and actual number of respondents from each stratum.

**Figure A-1**
**Montana Rural and Urban Regions**

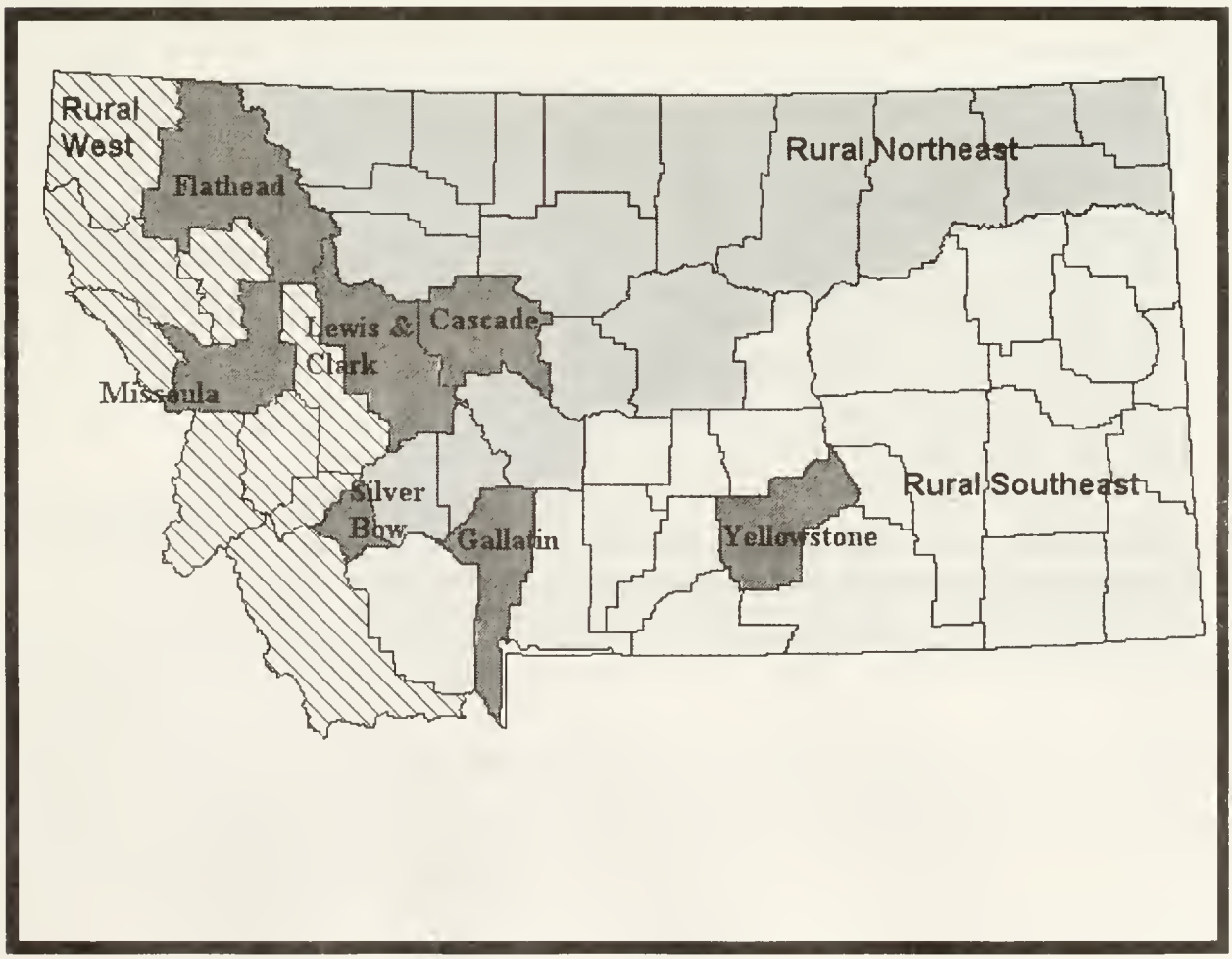


**Table A-1**
**Sampling Strata**

| | | ACTUAL | | PROPOSED | | | |
|---|---|---|---|---|---|---|---|
| | | Cases | Percent | Sample | Percent | Sample | Percent |
| Montana | | 5,074 | 100.0 | 6,750 | 100.0 | 8,800 | 100.0 |
| West Region | | 1,743 | 34.4 | 2,150 | 31.8 | 2,800 | 31.8 |
| Missoula | | 378 | 7.4 | 460 | 6.8 | 600 | 6.8 |
| Flathead | | 374 | 7.4 | 460 | 6.8 | 600 | 6.8 |
| Butte-Anaconda | | 311 | 6.1 | 460 | 6.8 | 600 | 6.8 |
| Rural west | | 680 | 13.4 | 770 | 11.4 | 1,000 | 11.4 |
| Southeast Region | 1,661 | 32.7 | 2,300 | 34.1 | | 3,000 | 34.1 |
| Yellowstone | | 341 | 6.7 | 460 | 6.8 | 600 | 6.8 |
| Gallatin | | 327 | 6.4 | 460 | 6.8 | 600 | 6.8 |
| Rural | 993 | 19.6 | 1,380 | 20.4 | | 1,800 | 20.4 |
| Northeast Region | 1,670 | 32.9 | 2,300 | 34.1 | | 3,000 | 34.1 |
| Cascade | | 337 | 6.6 | 460 | 6.8 | 600 | 6.8 |
| Lewis & Clark | | 312 | 6.1 | 460 | 6.8 | 600 | 6.8 |
| Rural | 1,021 | 20.1 | 1,380 | 20.4 | | 1,800 | 20.4 |

The sample for the survey consisted of telephone numbers stratified by groups of telephone exchanges. The strata were created to as closely as possible resemble county and sub-county geography of the areas to be sampled. Within each stratum, each telephone number had an equal probability of selection for the survey. Within each household that participated in the survey, one person was selected at random to be the focus of the survey. The survey also collected information on the health insurance status of each person in the household and some demographic information about the primary wage earner in the household. Some demographic characteristics such as household income are household specific not person specific. If the target was a minor, a knowledgeable adult was asked the questions. The employment questions were directed at the person responsible for the minor child.

## Response Rate

A total of 5,074 interviews were completed. The overall response rate to the 2003 Household Survey was 75.2 percent. Table A-2 shows the response rate calculation.

**Table A-2**
**Household Survey Response Rate Calculation**

| | | |
|---|---|---|
| Total household contacts | | 6,747 |
| Refusals | 1,422 | |
| Non-interviews | | 144 |
| Perpetual appointments | | 107 |
| Completions | | 5,074 |
| Response Rate | | 75.2% |

## Weighting of Survey Responses

Statistical weights for the 2003 Household Survey were constructed to adjust for the fact that not all of the survey respondents were selected with the same probability, and to adjust for different response rates in different groups. Across the different geographic strata, telephone numbers were sampled with different probabilities, in order to achieve the survey objectives of obtaining a certain number of completed interviews in particular geographic areas. Also individuals from younger age groups were more likely to be non-respondents. Weights were also calculated for age and gender.

Households with more than one telephone line had a higher chance of being selected for participation in the survey than households with only one telephone line. Those households who purchased individual insurance policy had a higher incidence of multiple telephones. Those with lower incomes were somewhat more likely to have been without a telephone in the last 12 months. The un-insurance rate is conservative; weighting for telephone availability would increase the rate increase the number of uninsured.

## Income Estimates

In household surveys, respondents are often hesitant to report sensitive information such as income. A total of 755 of the respondents to the 2003 Household Survey were not asked the income questions on the survey. Approximately 67 percent of the remaining 4,319 respondents reported their actual income and 19 percent responded to questions that asked whether their income fell within a certain range. This level of non-response to the income questions is slightly less than that found in household surveys conducted nationally. Income was estimated or imputed for 560 of the respondents who did not answer the income questions. There was not enough information to impute the income of the remaining 61 respondents. Table A-3 shows the distribution of household income responses.

Income was estimated for a number of reasons. First, it allows all respondents to be included in calculations involving income such as uninsurance rates by poverty level and eligibility for public programs among the uninsured. Second, it attempts to adjust for non-response bias, since the characteristics of non-responders may vary from those of responders.

Income was estimated using direct substitutions and a hot deck procedure. The statewide median for a given occupation was substituted for the missing data if the occupation was available. With the hot deck procedure, cases with missing income data are compared to similar cases with complete income data. Cases with complete income data were compared to cases with missing income data if they matched on a set of variables related to employment status, occupation, age, education, and household size. An income value selected at random from the similar cases with complete income data was used to impute income for a case with missing income data. Figure A-2 compares survey household income with 2000 Census data for Montana.

Federal poverty levels for 2002 are shown in Table A-4.

**Table A-3**
**Income response and estimates**

| | | | |
|---|---|---|---|
| Total respondents | 5,074 | | |
| Legitimate skip | 755 | | |
| Income question asked | | 4,319 | 100.0% |
| | Actual income | 2,883 | 66.7% |
| | Categorical income | 815 | 18.9% |
| | Estimated (imputed) | 560 | 13.0% |
| | Not Enough Information | 61 | 1.4% |

Figure A-2 Household Income Comparisons 2002 Census and The Montana Household Survey, 2003

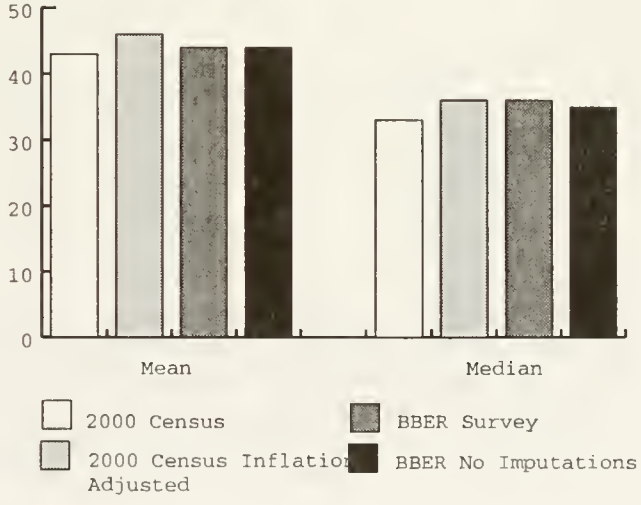



**Table A-4: Federal Poverty Levels**
**2002 Federal Poverty Levels**

| Family size (# persons) | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| Poverty Level (100%) | $8,860 | $11,940 | $15,020 | $18,100 | $21,180 | $24,260 | $27,340 |
| 125% Poverty Level | $11,075 | $14,925 | $18,775 | $22,625 | $26,475 | $30,325 | $34,175 |
| 150% Poverty Level | $13,290 | $17,910 | $22,530 | $27,150 | $31,770 | $36,390 | $41,010 |
| 200% Poverty Level | $17,720 | $23,880 | $30,040 | $36,200 | $42,360 | $48,520 | $54,680 |

Source: U.S. Census Bureau

# Appendix B: Employer Survey Methodology

The 2003 Montana Employer Survey was a stratified random telephone survey of businesses located in Montana covered by unemployment insurance. The data were collected by the Survey Research Center at The University of Montana-Missoula, Bureau of Business and Economic Research, from March 200 to May 2003. A key objective of the survey was to fill in gaps in our knowledge about Montana business offering of health insurance to their employees. The survey sampling methodology was designed to obtain a higher number of completed interviews from larger businesses because most Montana businesses have fewer than 10 employees. In order to achieve these goals, the survey was conducted as a stratified random sample, where the strata were business size.

The sample for the survey was drawn from the list of employers covered by unemployment insurance maintained by the Research and Analysis Bureau of the Montana Department of Labor and Industry. It was stratified by establishment size. Once calling began, it became apparent that some establishments were single individuals with no employees at the current time. These firms were dropped from the sample because their insurance coverage information was included in the household survey as self-employed individuals. Many firms in the sample were no longer in business. Table B-1 describes the sample.

Table B-1
Sample Description

| | Actual | | Located in Montana w/employees | | Sample | | Population | |
|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % |
| Total firms | 520 | 100.0 | 642 | 100.0 | 1,150 | 100.0 | 37,758 | 100.0 |
| <20 employees | 235 | 45.2 | 288 | 44.8 | 700 | 60.9 | 34,515 | 91.4 |
| 20-100 employees | 209 | 40.2 | 249 | 38.8 | 300 | 26.1 | 2,722 | 7.2 |
| > 100 employees | 76 | 14.6 | 105 | 16.4 | 150 | 13.0 | 521 | 1.4 |

The original 1,150 firms were sent a pre-survey notification letter before they were contacted by telephone. The letter explained who and what the survey was about, and that they would be contacted in one to two weeks by telephone interviewers for the Bureau of Business and Economic Research. It is easier to breakthrough gatekeepers with such a letter; Bureau interviewers are not "cold-calling". The letter also identifies firms that may have moved or are no longer in business by using the U.S. Postal Service's forwarding address requested service. Further location techniques such a Yellow Pages and directories established whether the firm was still in business.

## Response Rate

A total of 520 interviews were completed. The overall response rate to the 2003 Montana Employer Survey was 81.1 percent. No contact was made with 95 firms during the interview period. Many of these were large out-of-state corporations with Montana offices. Of those firms where contact was made, more than 95 percent answered the questions. Table B-2 shows the response rate calculation.

**Table B-2: Business Survey Response Rate Calculation**

| | |
|---|---|
| Total businesses located | 642 |
| Unable to contact | 95 |
| Contacted | 546 |
| Refusals | 26 |
| Completions | 520 |
| | |
| Response rate for contacts | 95.2% |
| Response rate for sample | 81.0% |

## Weighting of Survey Responses

Statistical weights for the 2003 Montana Employer Survey were constructed to adjust for the fact that not all of the firms were selected with the same probability. The weights did not affect the overall proportions so there was no additional gain in information accuracy. The weights did, however, statistically decreased the sample size of larger firms and decreased our ability to analyze the data and make comparisons that can be applied to the universe of Montana employers–small and large. It was therefore determined that weighting would distort the data for these larger firms. Table B-3 shows cell differences between weighted and unweighted data.

**Table B-3: Comparison of Weighted and Unweighted Data Firm Size by Health Insurance Offered as a Benefit to None, Some, or All Employees**

| | Unweighted | | | | Weighted | | | |
|---|---|---|---|---|---|---|---|---|
| | None | Some | All | N | None | Some | All | N |
| All firms | 33% | 26% | 41% | 520 | 51% | 14% | 36% | 520 |
| Less than 20 | 54% | 12% | 34% | 235 | 54% | 12% | 34% | 476 |
| 20-100 | 20% | 34% | 46% | 209 | 21% | 34% | 45% | 38 |
| More than 100 | 4% | 47% | 48% | 76 | | 50% | 50% | 6 |

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